

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

55-2

CERTIFICATE OF DEATH

Reg. Dist. No.

1173676

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 yrs.

Hospital, institution, or street address where death occurred:

5546 Wessling Lane

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Montgomery

City or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5546 Wessling Lane

(If rural, give LOCATION)

No

2.(a) Is veteran, name war.

3. (a) FULL NAME

HERBERT LUTHER ADAMS

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Augusta G. Adams

6.(c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) May 15, 1877

8. AGE: Years	Months	Days	It less than one day
71	71	2	5
			hrs. min.

9. Birthplace West Warren, Mass.
(Town, county, and state)

10. Usual occupation Administrative

11. Industry or business

12. Name Leander Adams

13. Birthplace West Brookfield, Mass.

14. Maiden name Emma J. Trowbridge

15. Birthplace West Warren, Mass.

16. Informant Augusta G. Adams

Address 5546 Wessling La., Bethesda, Md.

17. Burial Date thereof August 2, 1948
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Fort Lincoln Cemetery

Location Washington, D. C.

18. Funeral director Wm. Leander Peeples
Address 7557 Wisconsin Ave., Bethesda, Md.19. 7/31 1948 2pm E. Jones
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1948, a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 15 1948, to July 30 1948
and that I last saw him alive on July 20 1948

Immediate cause of death

Exhaust

Due to General exhaustion

Electrolyte disturbance primary

Carcinoma of rectum primary

Gastric ulcer secondary

and terminal

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

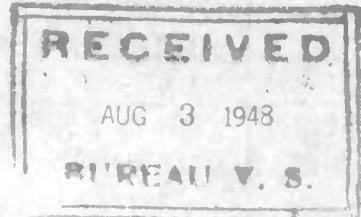
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other
Address 1520 1st St. Date signed 7/31/48



~~M~~ PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

07368
217

Reg. Dist. No. 217

1. PLACE OF DEATH:

County Montgomery
City or town Olney, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital

How long in hospital or institution?

3. (a) FULL NAME

John Frank Alderton

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife Mrs. Marie Alderton

7. Birth date of deceased (mo., day, yr.) SEPT. 13 1891 6 (c) If alive, give age 53 years

8. AGE: Years 51 Months 10 Days 8 Less than one day hrs. 0 min. 0

9. Birthplace Hayfield, Montg. Co. Maryland
(Town, county, and state)

10. Usual occupation Foreman

11. Industry or business

MOTHER FATHER Kirk Alderton

12. Name Kirk Alderton
13. Birthplace West Virginia

14. Maiden name Dora Wooster
15. Birthplace West Virginia

16. Informant Hospital records
Address Burial

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof July 24, 1948
(month) (day) (year)

Cemetery or crematory Burtonsville M.D.

Location Burtonsville, Md.

18. Funeral director Bob W. Barber

Address Burtonsville, Md.

19. Date rec'd by registrar July 23, 1948

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
City or town Spicerville
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21, 1948 at 3:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1, 1948 to July 21, 1948

and that I last saw him alive on July 21, 1948

Immediate cause of death Cerebral Hemorrhage DURATION 10 days

Due to Essential Hypertension many years

Due to:

Other conditions Bronchiectasis.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

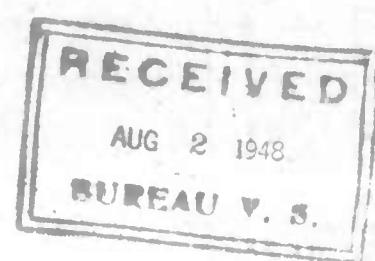
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Richard A. Yeter M.D. M. D. or other

Address Silver Spring, Md. Date signed 7/21/48



PLEASE WRITE PLAINLY, WITH INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07369
223

Reg. Dist. No.

1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 daysHospital, institution, or street address where death occurred: Washington Sanitarium + HospitalHow long in hospital or institution? 27 days

3. (a) FULL NAME

Ayerwas, Mr. Elliott

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male Jewish married

6. (b) Name of husband or wife

Mrs. Stella Ayerwas6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

April 18, 18978. AGE: Years 51 Months 3 Days 19 If less than one dayhrs. min. 9. Birthplace Brooklyn, New York

(Town, county, and state)

10. Usual occupation Salesman11. Industry or business Hudson Trading Company12. Name Neuman Ayerwas13. Birthplace Poland14. Maiden name Ethel Henrie15. Birthplace Poland16. Informant Washington San Hosp. recordsAddress Takoma Park 12, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof July 9, 1948

(month) (day) (year)

Cemetery or Cemetery National Hebrew CapitalLocation Washington D.C.18. Funeral director Goldberg Funeral HomeAddress 4717 - 9th Street N.W.19. Date rec'd by registrar July 8, 1948

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District Columbia CountyCity or town Washington D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1429 Montrose Ave N.E.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-8-1948 at 11:55 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6/10 1948 to 7/8 1948and that I last saw him alive on 7/8/481948

Immediate cause of death

Hypernephroma - rightkidney metastasis & lungs+ large blood vesselspelvis & abdomen

DURATION

4 mo

Due to

Due to

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations as above

Date of op.

Autopsy results

0

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

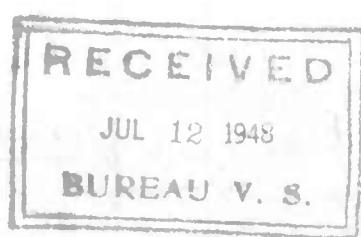
Injured at work?

23. SIGNATURE

John F. Brownberger M.D.

M. D. or other

Address Takoma Park Date signed 7/8/48



PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

07370

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park 12

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 mos 12 days

Hospital, institution, or street address where death occurred:

Washington Sanitarium & HospitalHow long in hospital or institution? 8 mos 12 days

3. (a) FULL NAME

Aylor, Mrs Sallie Jane

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female Caucasian widowed

6. (b) Name of husband or wife

Stanton B Aylor

6. (c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.)

January 24, 1869

8. AGE:

Years

Months

Days

If less than one day

79 5

17

.hrs. min.

9. Birthplace

Marshall, Fairquier, Virginia

(Town, county, and state)

10. Usual occupation.

House wife

11. Industry or business

12. Name Thomas Hawerence13. Birthplace Marshall, Va.14. Maiden name Marvinia Hawerence15. Birthplace Marshall, Va.16. Informant Wash. Sanitarium RecordsAddress Takoma Park 12 Maryland17. Removal Removal

(Burial, cremation, or removal. Which?)

Date thereof 7/11/48
(month) (day) (year)

Cemetery or crematory

Location Marshall, Va18. Funeral director B. F. Harrell & SonAddress Marshall, Va19. 7/11/48 19.....
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State VirginiaCounty FairquierCity or town Marshall

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

7/11/48 at 11:05 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3/24/46 1946 to 7/11/48 1948and that I last saw her alive on 7/11/48 1948

Immediate cause of death

Cancer of Breast with (48)
Generalized metastasis

Due to

Generalized metastasis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

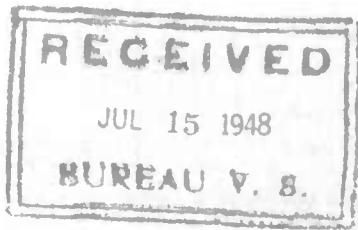
23. SIGNATURE

Howard J. Moore Jr.
Coroners Office Takoma Park

M. D. or other

Registrar

Date signed



1. **PLACE OF DEATH:**
 County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 38 days
 Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 38 days

3. (a) FULL NAMEBAILEY, George Terrel

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	C-US	Married

6. (b) Name of husband or wife Nannie Bailey

7. Birth date of deceased (mo., day, yr.) 11, June 1886

6. (c) If alive, give age years

8. AGE: Years 62 Months 0 Days 24 It less than one day

9. Birthplace Washington, D. C.
 (Town, county, and state)

10. Usual occupation Civil Service

11. Industry or business

MOTHER FATHER
 12. Name George Bailey
 13. Birthplace Virginia DEC.

14. Maiden name Susie (Unknown)
 15. Birthplace Virginia DEC.

16. Informant Wife: Mrs. Nannie Bailey,
 Address 1300 6th St. N.W. Washington, D.C.

17. Burial Date thereof 7-12-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National Cemetery

Location Arlington, Virginia

18. Funeral director W. Ernest Jarvis
 Address 1432 U. St. N.W., Washington, D.C.

19. 7-8 1948
 (Date rec'd by registrar)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

CERTIFICATE OF DEATHReg. Dist. No. 216

2. **USUAL RESIDENCE (HOME) OF DECEASED:**
 (For newborn infants give residence of mother)

State Washington, D.C. County
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1300 6th St. N.W.
 (If rural, give LOCATION)
 2.(a) Is veteran, name war WW I

3. (b) Social Security Number**MEDICAL CERTIFICATION**

20. **DATE OF DEATH** 8 July 1948 at 03:41 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
30 June 1948 to 8 July 1948
 and that I last saw h. im. alive on 8 July 1948

Immediate cause of death
Cerebral Hemorrhage

Due to Hypertension Arteriosclerosis 10 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Confirmed above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. **VIOLENCE:** If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

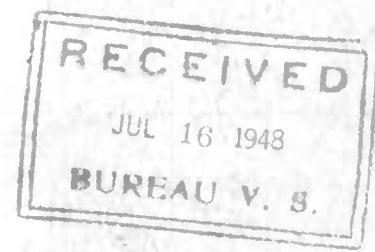
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. **SIGNATURE** J. E. F. Rankin
 J. E. F. RANKIN, LTJG MC USN
 M. D. or other

Address USNH Bethesda, Md. Date signed 7-8-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

07372

214

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County..... Montgomery

City or town..... Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

8383 Colesville Rd.

How long in hospital or institution?

3. (a) FULL NAME

Frank Baum

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife

Julia Baum

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

March 4, 1885

8. AGE:

Years

Months

Days

If less than one day

63

4

2

..... hrs. min.

9. Birthplace.....

Washington, D.C.
(Town, county, and state)

10. Usual occupation.....

Office Mgr.

11. Industry or business.....

Potomac Auto Sales

MOTHER FATHER

12. Name.....

John Baum

13. Birthplace.....

Maryland

14. Maiden name.....

Hedwig Smeigoski

15. Birthplace.....

Poland

16. Informant.....

Mrs Julia Baum

Address.....

8383 Colesville Road.

17. Burial.....

Date thereof..... July 8, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

St. Mary's

Location.....

Washington, D.C.

18. Funeral director.....

Warren E. Pumphrey, Inc.

Address.....

8434 Ga. Ave. Silver Spring, Md.

19. Date record by registrar.....

July 6, 1948

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Montgomery

City or town..... Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 8383 Colesville Rd.

(If rural, give LOCATION)

2. (a) If veteran, name war.....

NO

3. (b) Social Security Number

219-01-4536

MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 6, 1948, at 2:25 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

1 June, 1948, to 6 July, 1948

and that I last saw him alive on 6 July, 1948

Immediate cause of death..... R.T. heart

failure with pulmonary & hepatic edema

Due to..... Myocardial

disease

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

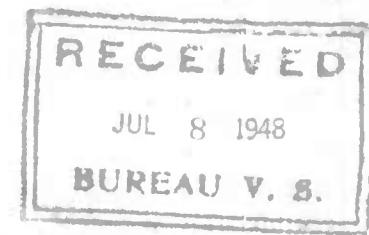
23. SIGNATURE.....

John S. Rogers, M.D.

M.D. or other

Address..... 9601 Sattler Pl. Silver Spring, Md.

Date signed..... July 6, 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07373

CERTIFICATE OF DEATH

94a
Reg. Dist. No. 216

1. PLACE OF DEATH

County MontgomeryCity or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution?

26 Days

3. (a) FULL NAME

Bellefonte, Lena

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Widowed

6. (b) Name of husband or wife

Louis Bellefonte

7. Birth date of deceased (mo., day, yr.)

Sept, 19 1855

6. (c) If alive, give age years

8. AGE:

Years
92Months
10

Days

If less than one day
hrs. min.

9. Birthplace

Washington, D.C.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

August Hoch

MOTHER

FATHER

12. Name

August Hoch

13. Birthplace

Germany

14. Maiden name

Christina Heppner

15. Birthplace

Germany

16. Informant

M. Charles R. Birmingham

Address

3 Thomapple St, Chevy Chase

Nephew

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

Cemetery or crematory

Congressional Cem.

Location

S. H. Hines, Co

18. Funeral director

2901 - 14 th St N.W.

Address

7/19 1948

(Date rec'd by registrar)

19. 1948221 E. John

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

MontgomeryCity or town Cherry Chase

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3 Thomapple St.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

19 July 1948

19

al 2²⁰ A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1946

19

to

19 July 1948

19

and that I last saw her alive on

19 July 1948

19

Immediate cause of death

Coronary artery disease

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Cause of injury

Injured at work?

23. SIGNATURE

Charles R. L. Haller M.D.

M. D. or other

Address 915-19th St. N.W. SuiteDate signed 19 July 1948

RECEIVED

JUL 24 1948

BUREAU V. S.

RECEIVED
JUL 12 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

07375

EVIDENCE FOR CHANGE
OF CAUSE OF DEATH SHOWN

CERTIFICATE OF DEATH

Reg. Dist. No. 216

D.O.B. 6 116 JUL 26 1948

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 DAYS

Hospital, institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution? 108 days

3. (a) FULL NAME

Mr. James B. Bronson

4. Sex

Male White Married

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

Gertrude b. Bronson

6. (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.)

August 23, 1872

8. AGE:

Years Months Days If less than one day

75 10 14 hrs. min.

9. Birthplace

Coxeter PEMBROKE New York

(Town, county, and state)

10. Usual occupation.

Retired from Navy Dept.

U.S. Gov't.

11. Industry or business

James Bronson

12. Name

ALBION, New York

13. Birthplace

Frances Newberry

14. Maiden name

New York

15. Birthplace

John Chapman M. Sc. in Law

16. Informant

6001 N. Wade Rd. Washington

Address

Cremation

Date thereof

July 8-48

(Burial, cremation, or removal, which?)

(month) (day) (year)

Cemetery or crematory

Cedars of Lebanon

Location

Penns. Ave. & 14th St. Wash. D.C.

Joseph Savers Sons

18. Funeral director

1756 Penns. Ave. N.W. Washington

Address

19. (Date rec'd by registrar)

7/10

18-48

W. E. Jones

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

Street No. 205 W. Thornapple St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

266-24-9317

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7, 1948, at 11:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 21, 1948, to July 7, 1948,

and that I last saw him alive on July 6, 1948.

Immediate cause of death Hypostatic pneumonia

CARCINOMA OF LUNG WITH METASTASIS TO LIVER

Passed 24 hours both lungs

Due to Chronic fibroid tuberculosis

2. Acute prostatitis

3. Cervical placenta spontanea

4. Tumor in the rectum area

5. Hypostatic pneumonia - 3 days

Other conditions: Ruptured uterus due to intestinal obstruction

duration of illness 10 days (Include pregnancy within 3 months of death)

Major findings of operations: No carcinoma found in

laparotomy bowel Date of op. June 28, 1948

GENERAL CARCINOMATOSIS, PRIMARY IN LUNG

Autopsy results: No cause found

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.. Date of ..

Where did injury occur? (City or town) (County) (State)

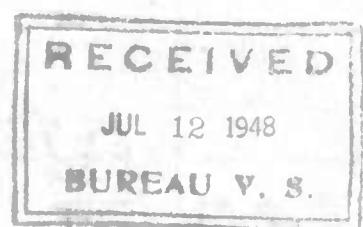
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John Chapman M.

M. D. or other

Address 6001 N. Wade St. Date signed July 7, 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

07376

Reg. Diet. No. 714

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Montgomery
 City or town Silver Spring, Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, Institution, or street address where death occurred:

20 Parkside Dr., Silver Spring, Md.

How long in hospital or institution?

3. (a) FULL NAME

Mrs. Edith D. Brownmiller

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female White Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age 85 years

7. Birth date of deceased (mo., day, yr.)

Sept. 26, 1862.

8. AGE: Years

Months

Days

If less than one day

8586

hrs.

min.

9. Birthplace

Salem, Oregon

(Town, county, and state)

10. Usual occupation

Music Teacher

11. Industry or business

John Henderson

MOTHER FATHER

John Henderson

13. Birthplace

?

14. Maiden name

Hannah Allen

15. Birthplace

Virginia

16. Informant

Dr. John F. Brownmiller

Address

20 Parkside Dr., Silver Spring, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof July 7, 1948.

(month) (day) (year)

Cemetery or crematory

Lewis Memorial Cemetery

Location

Asheville, N.C. (Buncombe Co.)

18. Funeral director

Arthur Stalder

Address

254 Carroll St. Takoma Park, Md.

19. Date rec'd by registrar

July 3 1948

Date rec'd by registrar

Josephine K. Schaeffer

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Silver Spring County Montgomery

(If outside city or town limits, write RURAL and give nearest town)

Street No.

20 Parkside Drive, Silver Spring
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 3, 1948, at 4:15 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 18 1948, to July 3 1948, and that I last saw her alive on July 27 1948.

Immediate cause of death

Cerebral Hemorrhage
Secondary Pneumonia

Due to

Arteriosclerotic Heart DiseaseDue to Hypertension, Cardiac Failure
with Arrhythmia, fibrillation for yearOther conditions Right Lighhouse
Thrombosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

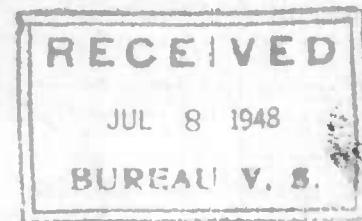
Injured at work?

23. SIGNATURE

Dr. John F. Mender M. D.

M. D. other

Address 504 Fulton Ave., Bethesda, Md.Date signed 7-3-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

74a

07377

216

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County..... Montgomery
City or town..... Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 7 days.....

Hospital, institution, or street address where death occurred:

U. S. NAVAL HOSPITAL, Bethesda, Md.

How long in hospital or institution?..... 7 days.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Washington, D. C. County.....

City or town..... (If outside city or town limits, write RURAL and give nearest town)

Street No..... 5735 Kansas Avenue, N. W.

(If rural, give location)

W.W.I

2.(a) If veteran, name war.....

3. (a) FULL NAME

BURGE, Roy Lester

3. (b) Social Security Number

4. Sex..... male 5. Color or race..... W-US 6.(a) Single, married, widowed, or divorced..... married

6.(b) Name of husband or wife..... Louise Irene Burge

7. Birth date of deceased (mo., day, yr.)..... June 25, 1899 6.(c) If alive, give age..... years

8. AGE: Years..... 49 Months..... 0 Days..... 10 If less than one day..... hrs..... min.....

9. Birthplace..... Iowa (Town, county, and state)

10. Usual occupation..... Civil Service

11. Industry or business

12. Name..... BURGE, John M. dec.

13. Birthplace..... Iowa

14. Maiden name..... FIX, Jennie dec.

15. Birthplace..... Kansas

16. Informant..... wife: Mrs. Louise I. Burge

Address..... 5735 Kansas Ave., N.W., Washington, D. C.

17. Burial Date thereof..... 7-9-48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Arlington National

Location..... Arlington, Va.

18. Funeral director..... S. H. HINES (A.P.)

Address..... 2901 14th St., N. W., Washington, D. C.

19. 68 7-5-48 19..... (Date rec'd by registrar)

Many G. Patterson
Mary G. Patterson
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 5 July 1948 at 7:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 28 June 1948 to 5 July 1948

and that I last saw him alive on 5 July 1948

Immediate cause of death

Leukemia, Acute, type undetermined 6 wks.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results..... Same

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

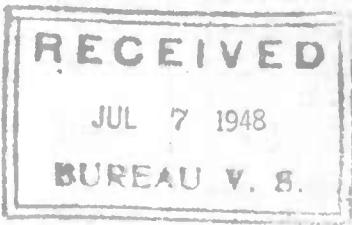
Means of injury

Injured at work?

23. SIGNATURE..... Wm. A. DINSMORE, Jr., LCDR MC

M. D. or other USN

Address..... USNH Bethesda, Md. Date signed..... 7-5-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92c

07378

CERTIFICATE OF DEATH

Reg. Dist. No. 714

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

313 Highview Ave.

How long in hospital or institution?

3. (a) FULL NAME

Byron, Mr. Karl Kearney

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife

Blanche Hedrick Byron

7. Birth date of deceased (mo., day, yr.)

4-1-01

6. (c) If alive, give age 46 years

8. AGE:

Years Months Days If less than one day
47 3 30 hrs. min.

9. Birthplace

Franklin County, North Carolina
(Town, county, and state)

10. Usual occupation

CPA - Junior Accountant

11. Industry or business Reconstruction Finance Corp.

12. Name

John L. Byron

13. Birthplace

Franklin County, North Carolina
Carolyn Kearney

14. Maiden name

Franklin County, North Carolina
Blanche Byron

15. Birthplace

Blanche Byron

16. Informant

Blanche Byron

Address

313 Highview - Silver Spring, Md.

17. Burial / Cremation

Date thereof Aug 1, 1948
(Burial, cremation, or removal. Which?)

Cemetery or crematory

Oaklawn Cemetery

Location

Louisburg, Franklin Co., N.C.

18. Funeral director

Warren E. Humphreys, Inc.

Address

Silver Spring, Md.

19. Date rec'd by registrar

July 3, 1948 Josephine Schaeffer

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 313 Highview Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

7-31-48 at 6:20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-18-39 to 7-31-48

and that I last saw him alive on 7-31-

Immediate cause of death

Acute Myocardial Failure

Due to Chronic Passive Congestion of Lungs, Stomach, Liver, Spleen

Due to Atherositic Endocarditis 5 months

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results As above done 7/31/48

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

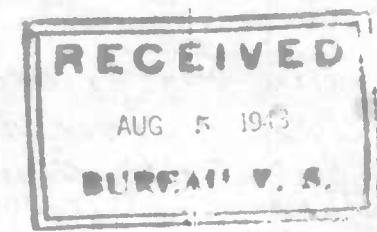
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work? (Signature)

23. SIGNATURE

Address 8005 Worthington Drive, Silver Spring, Md. Date signed 7-31-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

462

07379
216

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Montgomery

City or town..... Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

1 month

How long in above place of death?

Hospital, Institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution?

1 month

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D.C.

County.....

Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 1443 Lily Ponds Drive, N. E.

(If rural, give LOCATION)

3. (a) FULL NAME

CALDWELL, Mary Elizabeth

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
female	W-US	married

6. (b) Name of husband or wife..... Daniel A. Caldwell

7. Birth date of deceased (mo., day, yr.)..... April 26, 1901

8. AGE:	Years	Months	Days	If less than one day
	47	3	2	hrs. min.

9. Birthplace..... Kentucky

(Town, county, and state)

10. Usual occupation..... housewife

11. Industry or business

12. Name..... SILVESTER, SHOUSE

13. Birthplace..... Ky.

14. Maiden name..... EVA SHELY

15. Birthplace..... Ky.

16. Informant..... Mr. Daniel A. Caldwell,

Address..... 1443 Lily Ponds Dr., N.E., Wash., D.C.

17. burial

Date thereof..... 8-2-48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory..... Arlington National

Location..... Arlington, Va.

18. Funeral director..... Reuben Pumphrey

Address..... 7557 Wisconsin Ave., Bethesda, Md.

19. 7-28..... 19 48..... (Date rec'd by registrar)

Mary C. Patterson
Mary C. Patterson
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 28 July 1948 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 28 June 1948 to 28 July 1948 and that I last saw her alive on 28 July 1948.

Immediate cause of death..... Adenocarcinoma of transverse colon with generalized metastasis and intestinal obstruction

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Cervix, ovaries, uterus, colon & generalized metastasis Date of op. 7/8/48

Autopsy results..... confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Paul Peterson, Capt. MC USN or other

Address..... USNH Bethesda, Md. Date signed..... 7-28-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 93d 07389

PLEASE WRITE NEATLY, WITH UNFADING INK. Supply every item of information carefully. The correct age especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Lorraine E. Case

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white widow

6. (b) Name of husband or wife.....

John L. Case

7. Birth date of deceased (mo., day, yr.)

Sept 17 - 1880

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

67 10 9

.hrs. . min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Burial.....

(Burial, cremation, or removal. Which?)

Date thereof..... (month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. Date rec'd by registrar.....

19. Date of.....

Registrar.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

City or town.....

Street No.....

County.....

(If outside city or town limits, write RURAL and give nearest town)

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1948 to July 26 1948 and that I last saw him alive on July 18 1948.

Immediate cause of death..... arteriosclerotic cardio-vascular disease.

Due to..... chronic alcoholism

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

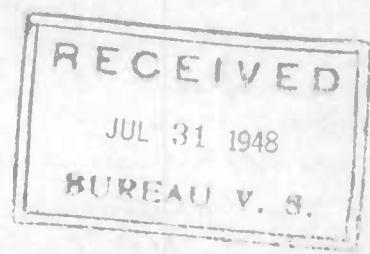
Injured at work?

23. SIGNATURE.....

Address.....

M. D. or other

Date signed 7/27/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

51b

07381
216

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County

Montgomery

City or town

Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

1 month, 21 days

Hospital, institution, or street address where death occurred:

U. S. NAVAL HOSPITAL, Bethesda, Md.

How long in hospital or institution?

1 month, 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington, D. C. County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

3711 Huntington St., N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war

Sp.Am.

3.(a) FULL NAME

CHRISTIAN, Paul John

3.(b) Social Security Number

4. Sex

Male

5. Color or race

W-142

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Laura L. Christian

7. Birth date of deceased (mo., day, yr.)

September 7, 1871

6.(c) If alive, give age.....years

8. AGE:

Years
76Months
9Days
24

If less than one day

. hrs. min.

9. Birthplace

La.

(Town, county, and state)

10. Usual occupation

unemployed

11. Industry or business

MOTHER FATHER

12. Name CHRISTIAN, Paul J.

dec.

13. Birthplace

Pa.

14. Maiden name

DUGGAN, Mary

dec.

15. Birthplace

Va.

16. Informant

wife: Mrs. Laura L. Christian

N.W.

Address 3711 Huntington St., Washington, D. C.

burial

Date thereof 7-6-48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Arlington National Cemetery

Location

Arlington, Va.

18. Funeral director

W. W. CHAMBERS

O. B. Chapman

Address

1400 Chapin St., N.W.

Washington, D. C.

19. (Date rec'd by registrar)

7-2-

1948

Mary C. Patterson

Registrar

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

1 July

1948 4:12 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10 May 1948 to 1 July 1948

and that I last saw h. in alive on

1 July 1948

Immediate cause of death

Septicemia

DURATION

2 days

Due to Pyelonephritis

?

Due to Cancer - prostate

?

Other conditions Cardiac arrhythmia

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results Confirmed alive

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

P. L. Bates

P. L. BATES, Lt JG MC USN

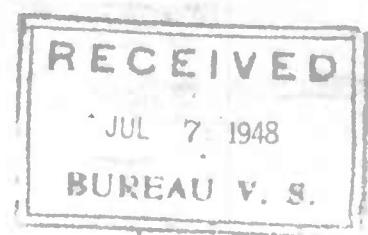
M. D. or other

USNH Bethesda, Md.

7-2-48

Address

Date signed



PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07382

94a

Reg. Dist. No. 19/217

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 hours 14 minutes

Hospital, institution, or street address where death occurred:

Montgomery County General Hospital

How long in hospital or institution? 5 hours 14 minutes

3. (a) FULL NAME

CECIL FORD COLE

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Widowed

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age — years

JUNE 19, 1876

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

72

0

28

9. Birthplace

Laurel, Md

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

Henry Deamade Cole

13. Birthplace

Laurel, Md

14. Maiden name

Martha Mountjoy

15. Birthplace

Laurel, Md

16. Informant

Stanley Cole (Son)

Address

Highland, Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Mt. Zion

Location

Highland, Md

18. Funeral director

J. P. Negus

Address

Ellwood City Md

19. July 19, 1948

(Date rec'd by registrar)

John D. Longman

Per B. E. Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Howard

City or town Highland (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1948 at 9:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 16, 1948, to July 16, 1948, and that I last saw him alive on July 16, 1948.

Immediate cause of death

Coronary Occlusion

(Posterior myocardial infarction)

Coronary Sclerosis

DURATION

1 day

? Years

Due to

Other conditions

Overdose Nitro

(Nitroglycerin)

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

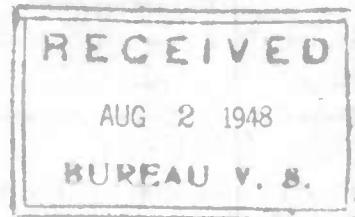
Injured at work?

23. SIGNATURE

Chas. J. Mathews M. D. or

Address Sandy Spring Md Date signed 7/16/48

1876-6-18
72-0-28
1948-X-X
6-46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07383

CERTIFICATE OF DEATH

93d
Reg. Dist. No. 217

1. PLACE OF DEATH:

County

City or town Rural Edward Md
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? All the time

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male col Widowing

6. (b) Name of husband or wife

Elizabeth Cook

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 22 18728. AGE: Years 75 Months 11 Days 7 If less than one day
..... hrs. min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation none11. Industry or business none12. Name William H. Cook13. Birthplace Md14. Maiden name Mary Nugent15. Birthplace Maryland16. Informant Mary CookAddress Edward Md17. Burial Date thereof July 20 1948
(Burial, cremation, or removal. Which) (month) (day) (year)Cemetery or crematory Mt Zion RdLocation Maryland18. Funeral director Bob W. BarberAddress Jeffersonville Md19. Date rec'd by registrar July 19 1948

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MarylandCity or town Rural Edward Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 17 1948 at 2 55 A.M.
I CERTIFY that death occurred on the date above stated; that I attended deceased from April 6 1948 to July 17 1948 and that I last saw him alive on July 16 1948

Immediate cause of death

Apoplexy July 14

Due to Cerebral Hemorrhage

Due to Arterosclerotic

Other conditions Hypertension

+ Chronic Myocardial Disease

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

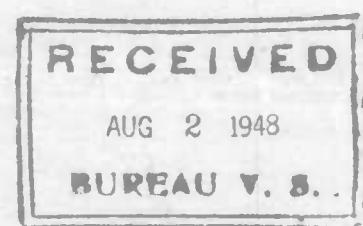
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

Webster Sewell MD
M. D. or otherAddress North Beach Md Date signed July 17 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

07384

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: **Montgomery**

City or town: **Bethesda (rural)**
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

U.S. Naval Hospital, Bethesda, Md.

How long in hospital or institution?

3. (a) FULL NAME

CROPPER, Stewart

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	W - US	Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) **13 July 1948** (5,35 AM)

8. AGE: Year **9** Months **5** Day **5** If less than one day **5** hrs. **5** min.

9. Birthplace: **Bethesda (rural)**
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name: **CROPPER, Harold Edward**
13. Birthplace: **Ohio**

14. Maiden name: **IANNIELLO, Anna**
15. Birthplace: **Pennsylvania**

16. Informant: father: Mr. Harold E. Cropper
Address: **626 D St., N. E., Wash., D.C.**

17. Burial: Date thereof: **7-15-48**
(Burial, cremation, or removal. Which?) **(month) (day) (year)**

Cemetery or crematory: **Arlington National**
Location: **Arlington, Virginia**

18. Funeral director: **W. W. Chambers** *g.*
Address: **517 11th St. S.E. Washington, D.C.**

19. Date reg'd by registrar: **7-19-48** *Many L. Patterson*
(Date reg'd by registrar) *Registrar*

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: **D.C.** County: **Washington**

City or town: **Washington**
(If outside city or town limits, write RURAL and give nearest town)

Street No. **626 D St., N. E.** (If rural, give LOCATION) *v*

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: **13 July** 19 **48** at **2:40 P.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **13 July** 19 **48** to **13 July** 19 **48**, and that I last saw him alive on **13 July** 19 **48**.

Immediate cause of death: **Atelectasis from lumps.** *Since Birth*

Due to: **Prematurity**

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Autopsy results: **Same as above** Date of op.:

PHYSICIAN: Please indicate the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: _____ Date of: _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury: _____ Injured at work? _____

23. SIGNATURE: **J. T. FOWLER, Jr., Cdr. MC USN** M. D. or other

Address: **USN H Bethesda, Md.** Date signed: **7-19-48**

RECEIVED

JUL 20 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07385

83a

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH:

Montgomery

County.....

Bethesda

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 weeks

Hospital, institution, or street address where death occurred:

107 East Glenbrook Road,

How long in hospital or institution? None

3. (a) FULL NAME

- - - - CELIA HANNAH CROSBY - - - -

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female

White

Widowed

6.(b) Name of husband or wife Orville W. Crosby
(deceased)

7. Birth date of deceased (mo., day, yr.) September 25th, 1868

8. AGE: Years 79 Months 79 Days 9 If less than one day 6 hrs. min.

9. Birthplace Eastham, Mass. (Town, county, and state)

10. Usual occupation None - Housewife

11. Industry or business None

MOTHER FATHER 12. Name John F. Walker

13. Birthplace Eastham, Mass.

14. Maiden name Ellen Harding

15. Birthplace Orleans, Mass.

16. Informant Comd. Kenneth G. Crosby

Address Bethesda, Maryland

17. Burial-Transit Date thereof July 4, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Orleans Cemetery

Location Orleans, Mass.

18. Funeral director Wm. L. Andrew Pumpelly

Address Bethesda, Maryland

19. 7/2/48
(Date rec'd by registrar)John E. Gober
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

Street No. 107 East Glenbrook Road,

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

1 July

1948, at 5:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

17 June

1948, to

1 July

1948.

and that I last saw her alive on 1 July 1948.

Immediate cause of death

Cerebral Hemorrhage -

DURATION

8 Days.

Due to: Central Sclerosis

Generalized -

Due to: Atrial Fibrillation -

Other conditions: Mental Depression -

2 Weeks.

(Include pregnancy within 8 months of death)

Major findings at operations

none.

Date of op.

Autopsy results: not done.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur?

(City or town)

(County)

(State)

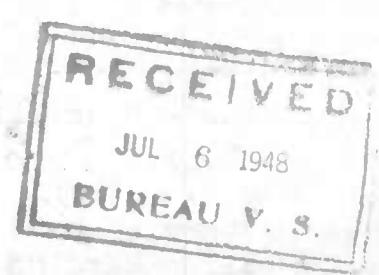
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John S. Ball
7936 Georgetown Rd.,
Bethesda, Maryland
Date signed 2 July 48
M. D. or other



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If not correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

14547

CERTIFICATE OF DEATH

186a

073866

Reg. Diat. No.

1. PLACE OF DEATH:

County

City or town

Montgomery

Bettles

How long in above place of death?

4 hrs.

Hospital, institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution?

4 hrs.

3. (a) FULL NAME

E. Wallace Crown

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male white single

6. (b) Name of husband or wife

none

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

March 8, 1888

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

8. Birthplace

Montgomery County, Md.

(Town, county, and state)

10. Usual occupation

none

11. Industry or business

none

MOTHER

FATHER

12. Name

John Crown

13. Name

13. Name

14. Name

15. Name

16. Name

17. Name

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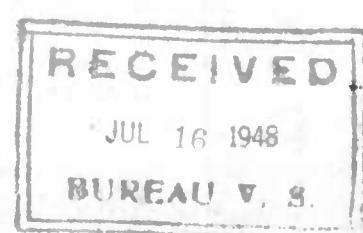
306. Name

307. Name

308. Name

309. Name

310. Name



PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

170e
Reg. Dist. No. 57387
516

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1. HourHospital, Institution, or street address where death occurred: Suburban HospitalHow long in hospital or institution? 1 hr

3. (a) FULL NAME

Forest M. Crown4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Dora Crown7. Birth date of deceased (mo., day, yr.) March 2 18966. (c) If alive, give age years8. AGE: 52 Years 11 Months 0 Days 0 If less than one day hrs. 0 min.9. Birthplace Derwood md

(Town, county, and state)

10. Usual occupation Asst. pay. master

11. Industry or business

12. Name John Q. Crown13. Birthplace md14. Maiden name Mary Shannon15. Birthplace md16. Informant Cpl. C.A. CrownAddress Derwood, Maryland17. Burial Forest Oak Cemetery
(Burial, cremation, or removal. Which?)Date thereof August 3, 1948
(month) (day) (year)

Cemetery or crematory

Location Gaithersburg, Maryland18. Funeral director W.M. LandersAddress 7557 Wisconsin Ave., Beth. Md.19. 8/3 1948
(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State marylandCounty MontgomeryCity or town Derwood

(If outside city or town limits, write RURAL and give nearest town)

Street No. None

(If rural, give LOCATION)

2. (a) If veteran, name war World War I

3. (b) Social Security Number

217-03-5048

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30, 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

def med exm case 19 19 19and that I last saw h. alive on 19 19 19

Immediate cause of death

Inter Thoracic HematomaCrushed chest (at

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

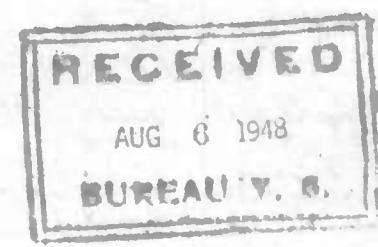
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 7/30/48Where did injury occur new Rockville Mary md (City or town) (County) (State)Injured at home, farm, industry, public place (where?) highwayMeans of injury auto accident Injured at work? no

23. SIGNATURE

Frank J. Brookhart M.D. M. D. or otherAddress 10100 Rockville Rd Date signed 7/30/48



MARYLAND STATE DEPARTMENT OF HEALTH X

2411 N. Charles St., Baltimore

50

07389
223

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County... Montgomery

City or town... Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 days

Hospital, Institution, or street address where death occurred:

Washington Sanitarium & Hospital

How long in hospital or institution? 9 days

3. (a) FULL NAME

Miss EONA R. DANFORTH

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

Jan 6th 1889

8. AGE:

Years Months Days If less than one day

59

6

7

hrs.

min.

9. Birthplace

Washington, D.C.

(Town, county, and state)

10. Usual occupation

Clerk

11. Industry or business

Government Pentagon Bldg.

R. FOSTER Danforth

12. Name

MOTHER FATHER

Minerva Sheldon

13. Birthplace

New York, State

14. Maiden name

Philadelphia Pennsylvania

15. Birthplace

Washington San. Hospital records

16. Informant

Takoma Park, Md.

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof July 15, 1948

(month)

(day)

(year)

Cemetery or crematory

Glenwood Cemetery

Location

Washington, D.C.

18. Funeral director

The 27th funeral Co.

Address

2901 14th St. N.W.

19. Date rec'd by registrar

July 13, 1948

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Columbia

City or town Washington, D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5701 Nebraska Ave. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

July 13 1948 at 10⁵² M

21. I CERTIFY that death occurred on the date above stated: That I attended deceased from

July 5 1948 to July 13 1948, and that I last saw her alive on July 12, 1948.

Immediate cause of death

Metastatic Carcinoma of left lung.

Due to Carcinoma of left breast.

Due to

Other conditions Pleurisy with effusion left

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results O

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Arthur E. Coyne M.D. M. D. or other

Address Takoma Park, Md. Date signed July 13, 1948

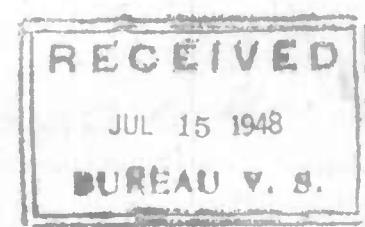
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LINE CORRECTAGE
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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9-45-15M

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07389

183

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County

Montgomery

City or town

Patuxent River, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

1/2 day

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Donald Dasher

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white married

6. (b) Name of husband or wife

Anna Elizabeth

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 2, 1927

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

(Town, county, and state)

Baltimore, Md.

10. Usual occupation

Taxicab driver

11. Industry or business

MOTHER FATHER

William E. Dasher

12. Name

Peter W. Va.

13. Birthplace

Sole Grace & Cate

14. Maiden name

Romney, Jr. Va.

15. Birthplace

Romney, Jr. Va.

16. Informant

William E. Dasher

Address

1010 31st St., Va., R. I. D.

17. Burial

Burial

Date thereof July 8, 1948

(Burial, cremation, or removal, which?)

(month) (day) (year)

Cemetery or crematory

ST. Peter's Cemetery

Location

Baltimore, Md.

18. Funeral director

R. W. O. Hall

Address

Occoquan, Va.

19. Date reg'd in registrar

July 12th 1948

2nd 3rd

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Va

County

Fairfax

City or town

Fairfax Station

Street No.

R. 2. D.

2. (a) If veteran, name war

World War II

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

July 5

1948 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 5th 1948 to 1948

and that I last saw him alive on 1948

Immediate cause of death

Asphyxia by drowning
(accident)

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of 7/5/48

Where did injury occur?

County 7/5/48

Injured at home, farm, industry, public place (where?)

(State) 7/5/48

Means of injury

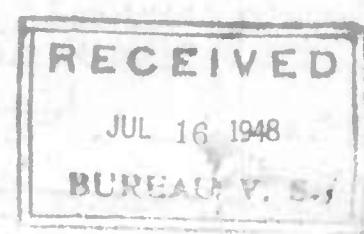
Injured at work? no

Frank J. Broschart M.D.

Dept. of Health & Sanitation M.D. or other

Address 7/6/48

Date signed 7/6/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07394
214

CERTIFICATE OF DEATH

83a
Reg. Dist. No.

1. PLACE OF DEATH:

County *Montgomery*City or town *White Oak* (Capt.)
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *eleven years*

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Henry Howard

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*Male**C / married*

6. (b) Name of husband or wife

Emmie F. Davis

7. Birth date of deceased (mo., day, yr.)

June 6, 1892

6. (c) If alive, no. of age years

8. AGE:

Years *56*

Months

Days

If less than one day

hrs. min.

9. Birthplace

Md.
(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

Richard Davis

12. Name

Richard

13. Birthplace

Md.

14. Maiden name

Georgia Thomas

15. Birthplace

Md.

16. Informant

Emmie F. Davis

Address

White Oak, Md. Silver Spring

17. Burial

*Burial*Date thereof *July 11, 1948*
(month) (day) (year)

Cemetery or crematory

woodlawn

Location

Washington, D.C.

18. Funeral director

Robert L. Snowden

Address

Rockville, Md.

19. Date rec'd by registrar

July 7, 1948

(Date rec'd by registrar)

Josephine M. Schaeffer

Registers

Address

Dorothy M. Davis

M. D. or other

Date signed

7-4-48

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Montgomery*City or town *White Oak* (If outside city or town limits, write RURAL and give nearest town)Street No. *rural* Silver Spring (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

*July 4, 1948, at 11:00 A.M.*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
April 12, 1934, to July 4, 1948,
and that I last saw him alive on *July 21, 1948.*

Immediate cause of death

Henry Howard, a 56 year old Negro male, died of a cerebral hemorrhage, a complication of arteriosclerosis.

Due to

Arteriosclerosis

Due to

Hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Registers

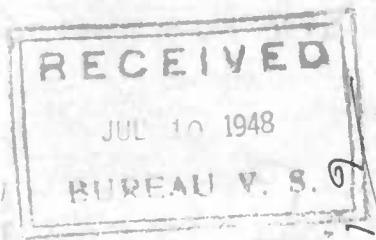
Address

Webster Sewell M.D.

M. D. or other

Date signed

7-4-48



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PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07391

516

CERTIFICATE OF DEATH

Reg. Distr. No. 223

1. PLACE OF DEATH:

County Montgomery County
 City or town Takoma Park in MD
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 daysHospital, institution, or street address where death occurred: Washington Samarium & HospitalHow long in hospital or institution? 6 days

3. (a) FULL NAME

John Davis, Sr.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male Cauc. MarriedB. (b) Name of husband or wife Mrs. Charlotte Davis

7. Birth date of deceased (mo., day, yr.)

July 10, 1883.6. (c) If alive, give age 55 years

8. AGE:

Years	Months	Days	It less than one day
<u>65</u>	<u>0</u>	<u>17</u>	<u>6</u> hrs. <u>27</u> min.

9. Birthplace

Belfast, Ireland

(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

MOTHER FATHER

William Davis13. Birthplace Ireland14. Maiden name Sarah Phillips15. Birthplace Ireland16. Informant Mrs. Charles HallAddress 502 Flower Ave Takoma Park, MD

17. Burial

(Burial, cremation, or removal. Which)

Date thereof July 31, 1948

(month) (day) (year)

Cemetery or crematory

Geo. Washington Memorial CemeteryLocation Big Road Extended, Shadyvale, Md.

18. Funeral director

G. Arthur WaltersAddress 264 Carroll St. Wash. D.C.

19. July 28 1948

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County P.G.C.City or town Berwyn, MD
 (If outside city or town limits, write RURAL and give nearest town)Street No. Cherry Hill Trailer Park
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

215-14-7136.

MEDICAL CERTIFICATION

20. DATE OF DEATH

7-281948 at 6:30

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

1948 to 7-28 1948and that I last saw him alive on 7-28-48

Immediate cause of death

Coronary Occlusion

DURATION

3-4 daysDue to Arteriosclerotic heart disease (year)UnknownDue to Generalized arteriosclerosis

Other conditions

Bronchopneumonia 1 dayProstatic hypertrophy

(Include pregnancy within 3 months of death)

Major findings of operations Abnormal prostate Date of op. 7-22-48Adenocarcinoma prostate

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

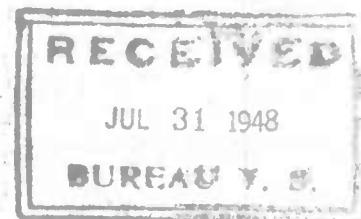
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ferdinand Stellebison M. D. or otherAddress 1835 Eye St. NW Date signed 7-28-48



Evidence for change of
birth date shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

M 116 G 116 AUG 10 1948 CERTIFICATE OF DEATH

07392

Reg. Dist. No. 217

1. PLACE OF DEATH:

County

Montgomery

City or town

Rural - Brookeville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

22 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Rachel Ann DUVALL

4. Sex

F

5. Color or race

Wh.

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Joshua Watkins Duvall

6.(c) If alive, give age years

64

7. Birth date of deceased (mo., day, yr.)

Nov. 26, 1892

1892

8. AGE:

Years
55

Months
7

Days
28

If less than one day

hrs.

min.

9. Birthplace

Howard County, Maryland

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Richard Parsley

12. Name

Howard County, Maryland

13. Birthplace

Alice Gue

14. Maiden name

Howard County, Maryland

15. Birthplace

Mary Virginia Brown

16. Informant

Brookeville, Maryland

Address

Burial

(Burial, cremation, or removal. Which?)

Date thereof
(month) (day) (year)

July

26

1948

Cemetery or crematory

Lemming's Brook

Location

Howard Co. Md.

18. Funeral director

Roy W. Barker

Address

Brookeville, Md.

19. (Date rec'd by registrar)

July 26, 1948

Death certificate

Destridet's Lawyer

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Montgomery

City or town

Rural - Brookeville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Rt. 97

2 miles N. of Brookeville

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 24 1948 at 12:20 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1948 to July 24, 1948 and that I last saw her alive on July 23, 1948

Immediate cause of death

Uremia

Congestive Heart Failure

Due to Arteriosclerotic Heart Disease

Due to

Other conditions Bronchopneumonia

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

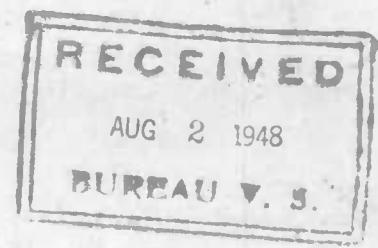
23. SIGNATURE

Richard A. Yates, M.D.

M.D. or other

Address RFD #1, Silver Spring, Md.

Date signed 7/27/48



PLEASE WRITE PLAINLY, WITH INK. Supply every item of information carefully. Use correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

123

07393

216

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 days
Hospital, Institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Md.
How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Dist. of Columbia County County
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1121 Buchanan St., N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war W.W. I

3. (a) FULL NAME

EHRLICH, Abraham Moses4. Sex Male Color or race W - U.S. 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Anna G. Ehrlich7. Birth date of deceased (mo., day, yr.) 15, February 18896.(c) If alive, give age years8. AGE: Years 59 Months 4 Days 27 It less than one day hrs. min.9. Birthplace New York
(Town, county, and state)10. Usual occupation Retired Army Officer

11. Industry or business

12. Name Samuel Ehrlich13. Birthplace Hungary DEC.14. Maiden name Laura Weil15. Birthplace Hungary16. Informant Wife: Anna G. EhrlichAddress 1121 Buchanan St. N.W., Washington, D.C.17. Burial Date thereof 7-14-48
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Arlington NationalLocation Arlington, Virginia18. Funeral director R. Danzansky & Son, 974
Address 3501 14th St. N.W., Washington, D.C.19. 7-12 - 1948 Mary C. Patterson
(Date rec'd by registrar) Mary C. Patterson Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH 12 July 1948 at 0825 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 July 1948 to 12 July 1948
and that I last saw him alive on 12 July 1948Immediate cause of death SepticemiaDue to Abscess perianal

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

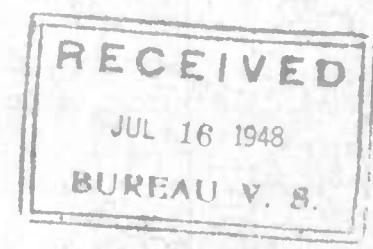
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE P. J. FUZY JR. T.D.G. MC USN
M. D. or otherAddress USNH Bethesda, Md. Date signed 7-12-48



PLEASE WRITE PLAINLY, WITH INK. Supply every item of information carefully. Use correct age. Physicians: please write the causes of death clearly and legibly. is especially important.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07394

131a

Reg. Dist. No. 223

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Montgomery County
 City or town Takoma Park 12, Md
(If outside city or town limits, write RURAL, and give nearest town)

How long in above place of death? 1 mo. 2 days

Hospital, institution, or street address where death occurred:

Washington Sanitarium and HospitalHow long in hospital or institution? 1 mo. 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Columbia County District of ColumbiaCity or town Washington
(If outside city or town limits, write RURAL and give nearest town)Street No. 315 B. St. S.E.

(If rural, give LOCATION)

3. (a) FULL NAME

Charles Winter Fernsner

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male Cauc. marriedAnna C. Fernsner

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Aug 2, 1866

8. AGE:

Years

Months

Days

If less than one day

hrs. 30 min.

9. Birthplace Four Blocks, Md

(Town, county, and state)

10. Usual occupation none

11. Industry or business

12. Name Samuel Fernsner13. Birthplace Germany14. Maiden name Martha Silver15. Birthplace Pennsylvania16. Informant Evelyn E. FernsnerAddress 315 B. St. S.E. Wash. D.C.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 29 July 1948

(month) (day) (year)

Cemetery or crematory

Location Meadowdale Pa.18. Funeral director Walter Funeral Home Inc.Address 301 E. Capitol St. Wash. D.C.19. (Date rec'd by registrar) July 26 1948

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1948 at 12:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 24 1948 to July 26 1948and that I last saw him alive on July 25 1948

Immediate cause of death

Congestive heart failure

DURATION

1 yr.Due to Arteriosclerosis
Heart disease

Due to

Other conditions Nephrosclerosis
Arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

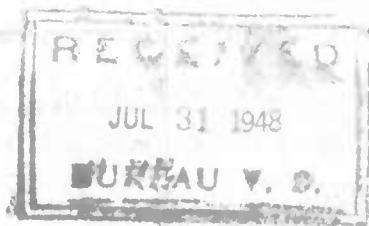
Means of injury

Injured at work?

23. SIGNATURE Russell A. Denner, M.D.

M.D. or other

Address Washington Sanitarium Date signed July 26 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

14707395

CERTIFICATE OF DEATH

26

Reg. Dist. No.

94a

1. PLACE OF DEATH:

County

City or town

Montgomery
Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution?

10 min.

3. (a) FULL NAME

Elliott Fineman

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male white married

6. (b) Name of husband or wife

Jeanette

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

May 25, 1908

8. AGE:

Years

Months

Days

If less than one day

40

2

4

hrs.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual occupation

Pharmacist

11. Industry or business

Sol. Fineman

12. Name

Russia

13. Birthplace

Mary Saron

14. Maiden name

Russia

15. Birthplace

Same

wife

16. Informant

Address

Same

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

3501 -

14th St. NW

7/29/48

(Date read by registrar)

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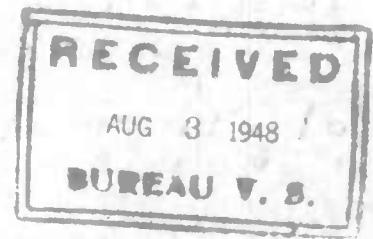
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

0739446

CERTIFICATE OF DEATH

Reg. Dist. No.

M
In Correct ageI
MARGIN RESERVED FOR BINDING

I

T
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
 County... Montgomery
 City or town... Chevy Chase
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 17 Yrs.
 Hospital, Institution, or street address where death occurred:
 6300 Stratford Road,
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State... Maryland County... Montgomery
 City or town... Chevy Chase
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 6300 Stratford Road,
 (If rural, give LOCATION)
 2.(a) If veteran, name war... No

3. (a) FULL NAME
 - - - - - ADA E. FLADD - - - - -

3. (b) Social Security Number
 - - - - - None - - - - -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife... John M. Fladd

7. Birth date of deceased (mo., day, yr.) December 9, 1860

8. AGE: Years	Months	Days	If less than one day
87	87	6	22
			hrs. min.

9. Birthplace... Syracuse, New York
 (Town, county, and state)

10. Usual occupation... None

11. Industry or business... None

MOTHER FATHER
 12. Name... William H. Barlow

13. Birthplace... Syracuse, New York

14. Maiden name... Emily - Unknown

15. Birthplace... Syracuse, New York

16. Informant... Mr. Barton P. Root

Address... Chevy Chase, Maryland

17. Burial-Transit Date thereof... July 5, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Horton Cemetery

Location... Orleans, Massachusetts HORTON HNS.

18. Funeral director... W.M. Random Pugh Jr.

Address... Bethesda, Maryland

19. 7/5 1948 Mrs E Johns
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1, 1948 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 31, 1948, to July 2, 1948, and that I last saw her alive on June 30, 1948.

Immediate cause of death... Diabetes

DURATION 4 years

Due to...

Due to...

Other conditions... Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op.

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

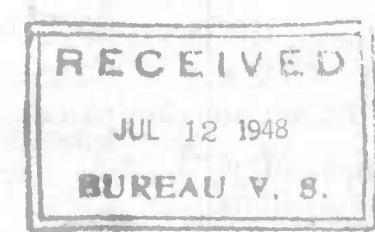
Injured at home, farm, Industry, public place (where?)

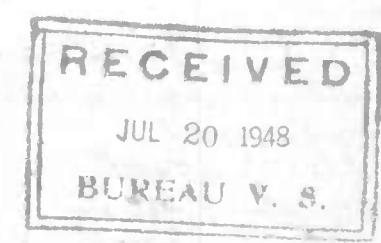
Means of injury

Injured at work?

23. SIGNATURE... Bradley Hodabius M.D. or other

Address... 313 West Bradley
 Chevy Chase, Maryland Date signed...





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07398

39c

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

8 days

How long in above place of death?

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

8 days

How long in hospital or institution?

3. (a) FULL NAME

GALEANO, Joseph

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

W-US

married

6. (b) Name of husband or wife

Jennie Galeano

6. (c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.)

January 1, 1896

8. AGE:

Years

Months

Days

If less than one day

52

6

26

.....hrs.min.

9. Birthplace

Italy

(Town, county, and state)

10. Usual occupation

Plasterer

11. Industry or business

MOTHER FATHER

GALEANO, Vincent

12. Name

Italy

13. Birthplace

Catherine ? dec.

14. Maiden name

Italy

15. Birthplace

Mrs. Jennie Galeano

16. Informant

Address 9005 Old Bladensburg Rd., Silver Spring, Md.

17. burial

Date thereof 7-30-48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Arlington National Cemetery or crematory

Location Arlington, Va.

18. Funeral director

Hanlon Funeral Home

Address 3831 Georgia Ave., N.W., Wash., D.C.

19. 7-27 19 48

(Date rec'd by registrar)

Mary C. Patterson

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County

Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 9005 Old Bladensburg Road

(If rural, give LOCATION)

WWI

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH July 27

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19. 48, at 4:46 A.M.

19. July 19. 48, to 27. July 19. 48

and that I last saw h. i.m. alive on 27. July 19. 48

Immediate cause of death

Bronchopneumonia

DURATION

10 days

Due to

Rocky Mountain Spotted Fever

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results Bronchopneumonia, Hepatitis, Nephritis, Md.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

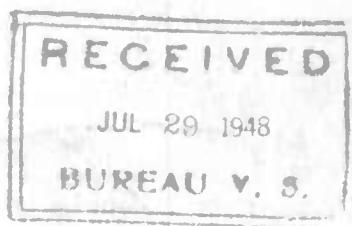
Injured at work?

Wm. A. Dinsmore, Jr., LCDR MC USN

M. D. or other

USNH Bethesda, Md.

Date signed 7-27-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incomplete or illegible answers will not be accepted. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

07399

211

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

City or town..... *Montgomery*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *One day*

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*Female Col. Married*6. (b) Name of husband or wife *Stanley D. Gibbs*7. Birth date of deceased (mo., day, yr.) *March 17 - 1897*8. AGE: Years *51* Months *4* Days *8* If less than one day9. Birthplace *Maryland*
(Town, county, and state)10. Usual occupation. *House Wife*11. Industry or business *House*12. Name *George W. Carroll*13. Birthplace *Maryland*14. Maiden name *Bethina Prather*15. Birthplace *Maryland*16. Informant *Stanley D. Gibbs*Address *Hypatia Bldg 2nd fl of*17. Burial, cremation, or removal. Where? *Buried*Date thereof *July 27 - 1948*

(Burial, cremation, or removal. Month) (day) (year)

Cemetery or crematory *Rocky Hill*Location *Montgomery Co. Maryland*18. Funeral director *Bob W. Bagger*Address *Elmwood*19. Date rec'd by registrar *July 27 1948*

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County..... *Maryland*

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *July 23* 1948 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 24 1948 to *July 25* 1948and that I last saw h. F. R. alive on *July 25* 1948Immediate cause of death *Stroke cardio**respiratory disease*

Dura

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

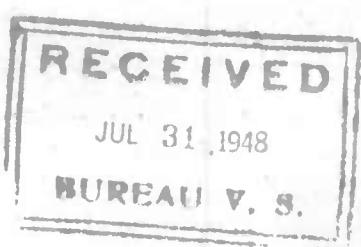
Meane of injury

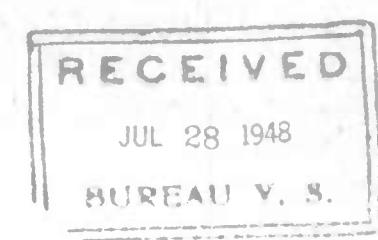
Injured at work?

23. SIGNATURE *James P. Kennedy, M.D.*

M. D. or other

Address *Washington, D.C.* Date signed *7/28/48*





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incomplete or illegible entries will be disregarded. Physicians: please write the causes of death clearly and legibly. This correct age is especially important.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

114e
07401
Reg. Dist. No. 216

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs.

Hospital, institution, or street address where death occurred:

St. Luke's Hospital
How long in hospital or institution? 4 days 16 1/2 hours

3. (a) FULL NAME

Adalia Reser Gorsuch

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife Ephraim Benjamin GorsuchDeceased

B. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7 18628. AGE: Years 86 Months 86 Days 29 If less than one day hrs. min.9. Birthplace Beloit Wisconsin
(Town, county, and state)10. Usual occupation House wife11. Industry or business None12. Name John J. Reser13. Birthplace UNKNOWN14. Maiden name Ana Moore15. Birthplace New Jersey16. Informant Anna Nora Gorsuch (daughter)Address 7600 Harling La Bethesda17. Burial Date thereof July 8, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or place Rocky Cedar Hill CemeteryLocation Washington, D. C.18. Funeral director Wm. Rankin PeaseAddress Bethesda, Maryland19. 7/8 1948
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)Street No. 4600 Harling Lane
(If rural, give LOCATION)2. (a) If veteran, name war No

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 6 194821. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 26 1948 to July 6 1948 and that I last saw her alive on July 5 1948

Immediate cause of death

Respiratory Disease

DURATION

Due to Atelectasis of the right lungDue to Fibrillation of the heart

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

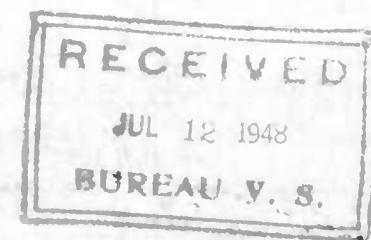
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank Jagger, M.D.
M. D. or otherAddress 5207 Wisconsin Ave. Date signed 7/6/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07402

216

Reg. Dist. No.....

CERTIFICATE OF DEATH

92a

1. PLACE OF DEATH:

County..... Montgomery
City or town..... Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 1 day

Hospital, Institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md. 1 Day

How long in hospital or institution?.....

3. (a) FULL NAME

GRIFFIN, Robert

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

Col.

married

6. (b) Name of husband or wife

Lucille Griffin

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) September 1, 1897

8. AGE: Years 50 Months 10 Days 0 If less than one day hrs. min.

9. Birthplace..... S. C. (Town, county, and state)

10. Usual occupation..... unknown

11. Industry or business

MOTHER FATHER 12. Name..... GRIFFIN, Samuel dec.

13. Birthplace..... S.C.

14. Maiden name..... Fanny ? dec.

15. Birthplace..... S.C.

16. Informant..... WIFE: Mrs. Lucille Griffin

Address 325 S. Patrick St., Alexandria, Va.

17. burial Date thereof July 7, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Arlington National Cemetery

Location..... Arlington, Va.

18. Funeral director..... Lloyd A. Lewis, *L.A. Lewis*

Address 800 Wolfe St., Alexandria, Va.

19. 7-2 1948 (Date rec'd by registrar)

Mary C. Patterson

Registrar

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Virginia County.....

City or town..... Alexandria

(If outside city or town limits, write RURAL and give nearest town)

Street No. 325 S. Patrick St.

(If rural, give LOCATION)

2. (a) If veteran, name war..... WWI

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH..... 1 July 48 19 at 7:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

30 June 48 to 1 July 48

and that I last saw h. I'm alive on 1 July 48

Immediate cause of death Congestive Heart Failure

Valvular Heart Disease, Aortic

Insufficiency

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

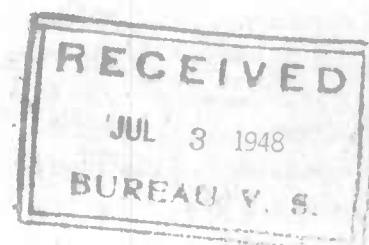
Months of injury

Injured at work?

D. E. BILLMAN, Lt. JG MC USN

M. D. or other

Address USNH Bethesda, Md. Date signed 7-2-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07403

466

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

Montgomery County General Hosp.

How long in hospital or institution?

3. (a) FULL NAME

Annie Harriday

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Col

widowed

6. (b) Name of husband or wife

Jesse Harriday

7. Birth date of deceased (mo., day, yr.)

April 11, 1895

6. (c) If alive, give age..... years

8. AGE:

Years
53Months
3

Days

If less than one day

hrs. min.

9. Birthplace.....

(Town, county, and state)

Mt. Zion, Montgomery, Md.

10. Usual occupation.....

none

11. Industry or business

Henson Johnson

MOTHER FATHER

12. Name.....

Montgomery Co., Md.

13. Birthplace.....

Neuvietha Dickey

14. Maiden name.....

Montgomery Co., Md.

15. Birthplace.....

Raymond Johnson

16. Informant.....

Brookville, Md. R.F.D.

Address

Burial

(Burial, cremation, or removal. Which?)

Date thereof.....

(month)

(day)

(year)

Cemetery or crematory.....

Mt. Zion

Location

Mt. Zion - Maryland

18. Funeral director.....

Robert L. Snowden

Address

Rockville, Md.

Date rec'd by registrar

7-14-48

1948

Signature

Esther B. Lawler

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Montgomery

City or town.....

Dexwood

R.F.D.

Street No.....

Mt. Zion

2. (a) If veteran, name war.....

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH

11 July

1948

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

Nov

1947

to

1948

and that I last saw her alive on

10 July 1948

Immediate cause of death.....

Cachexia

Due to.....

Ascert

Due to.....

Carcinoma of stomach
with liver metastases

DURATION

3 mo.

6 mo.

4 yrs

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE.

C. W. Ligon M.D.

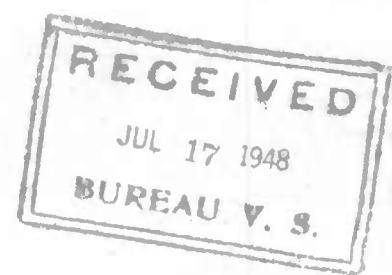
Address

Sandy Spring Md.

M. D. or other

Date signed

1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

07404

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:
County Montgomery
City or town Near Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
County Montgomery
State Maryland
City or town Near Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rockville Pike
(If rural, give LOCATION)
2.(a) If veteran, name war.

3. (a) FULL NAME
MARY JANE HARRISS

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife John Richard Harris

7. Birth date of deceased (mo., day, yr.) April 29, 1859
6.(c) If alive, give age years

8. AGE: Years 89 Months 2 Days 19 If less than one day
..... hrs. min.

9. Birthplace Potomac, Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER
12. Name Richard Collins
13. Birthplace Potomac, Md.

MOTHER
14. Maiden name Sarah A. Houser
15. Birthplace Montgomery County, Md.

16. Informant Mrs. Sue E. Young

Address Rockville Pike, Rockville, Md.

17. Burial Date thereof July 21, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Potomac Church Cemetery

Location Potomac, Md.

18. Funeral director Elle Tenbrun Peacock

Address Rockville, Maryland

19. 7-20 1948
(Date rec'd by registrar) E.P. Shoupe
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18, 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 10, 1948 to July 18, 1948
and that I last saw him alive on July 18, 1948

Immediate cause of death Cerebral apoplexy
arterio-sclerosis

Due to arterio-sclerosis

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

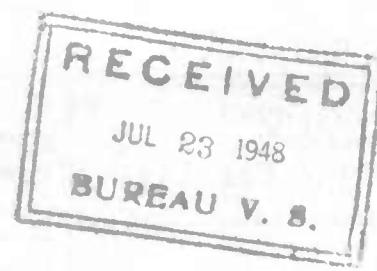
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE G. J. Hartley M.D.
M. D. or other

Address Rockville, Md. Date signed 7/19/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1970
07405

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County... Montgomery

City or town... Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 42 days

Hospital, Institution, or street address where death occurred:

U. S. Naval Hospital, Bethesda, Maryland

How long in hospital or institution? 42 days

3. (a) FULL NAME

Frank HART

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	W -US	Married

6. (b) Name of husband or wife. Florence Hart

7. Birth date of deceased (mo., day, yr.) 21 November 1871

6. (c) If alive, give age... years

8. AGE: Years	Months	Days	If less than one day
76	7	21	hrs. min.

9. Birthplace... Illinois

(Town, county, and state)

10. Usual occupation... Retired (Civil Service)

11. Industry or business

12. Name... James Alexander Hart

13. Birthplace... Illinois

14. Maiden name... Amanda Kessler

15. Birthplace

16. Informant... Wife: Florence Hart

Address 709 Allison St. N.W., Wash. D.C.

17. Burial... Date thereof... 7-15-48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Arlington National

Location... Arlington, Virginia

18. Funeral director S. H. HINES COMPANY

Address 2901 14th St. NW Washington D.C.

19. 7-14-48 19-48

(Date rec'd by registrar)

Mary C. Patterson

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Dist of Columbia County

City or town... Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 709 Allison St. N.W.

(If rural, give LOCATION) WHI

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH 12 July 1948 at 06:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1 June 1948 to 12 July 1948

and that I last saw h. in alive on 12 July 1948

Immediate cause of death

Natural: Prosthetic 3-4 weeks

obstruction of Benign prostatic

Due to: Hypertrophy 137 a

Due to: Cardiac decompensation

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

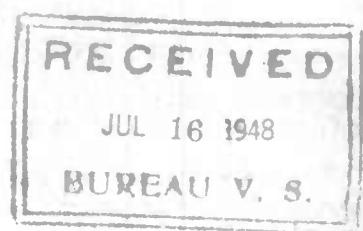
Means of injury

Injured at work?

23. SIGNATURE: R. N. WEBSTER, LT. U.S. NAVY or C. N. C. M. D. or C. M. D.

Address: U.S. Naval Hosp., Bethesda, Md. Date signed 7-14-48

VS A15 9-45-15M



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07406

CERTIFICATE OF DEATH

92d
Reg. Dist. No. 212

1. PLACE OF DEATH:

County

City or town

Montgomery
Sugarland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death:

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

James Edward Hebron
Male Colored Widowed

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo. day, yr.)

8. AGE:

Dec. 14 1880

Years Months Days If less than one day

hrs. min.

9. Birthplace

Sugarland, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER

FATHER

Robert Hebron

Md.

12. Name

13. Birthplace

Harriet Coates

Md.

14. Maiden name

15. Birthplace

Marietta Lee

Md.

16. Informant

Address

Burial

Cemetery or crematory

Location

18. Funeral director

Address

19. Address

Signature

Date

20. Address

Signature

Date

21. Address

Signature

Date

22. Address

Signature

Date

23. Address

Signature

Date

24. Address

Signature

Date

25. Address

Signature

Date

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

Montgomery
Sugarland

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

215-14-7168

MEDICAL CERTIFICATION

2D. DATE OF DEATH

Grey 21 1958 at 10:05 P.M.

I CERTIFY that death occurred on the date above stated; That I attended deceased from

Sugland Jan 19 10 19

and that I first saw h. alive on

Immediate cause of death

Acute Cardiac Dilatation

Due to

chronic Salivary Gland Disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Frank J. Borchard M.D.

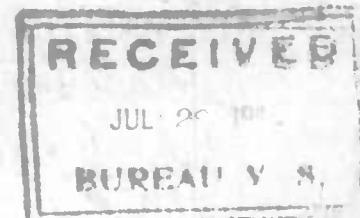
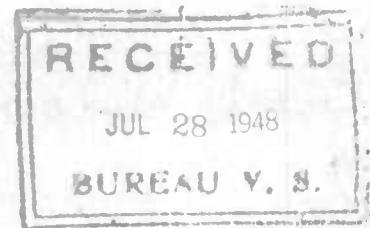
deceased

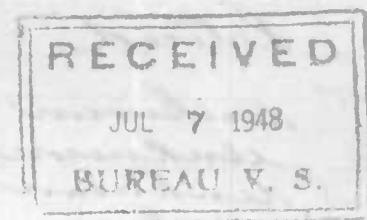
M. D. or other

Address

Gaithersburg Md. Date signed 7/22/58

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incomplete or illegible entries will not be accepted. Physicians: please write the causes of death clearly and legibly.





MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07408

CERTIFICATE OF DEATH

108
Reg. Dist. No. 216

1. PLACE OF DEATH:
 County..... Montgomery County
 City or town..... Rural-Near Rockville Maryland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
 Hospital, institution, or street address where death occurred:
 WAVERLY SANITARIUM - Near Rockville, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State..... Maryland County..... Montgomery
 City or town..... Chevy Chase, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 5616 Western Avenue, Chevy Chase, Md.
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME
 FRANK VICTOR HOLTMAN

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife.....
 6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) March 24th, 1860

8. AGE: Years	Months	Days	11 less than one day
88	3	20 hrs. min.

9. Birthplace..... SWEDEN
 (Town, county, and state)

10. Usual occupation..... Retired

11. Industry or business.....
 12. Name..... Holtman

MOTHER FATHER
 13. Birthplace..... Sweden
 14. Maiden name..... Unknown

15. Birthplace..... Sweden

16. Informant..... Mr. Dudley F. Holtman
 Address..... 5616 Western Ave, Chevy Chase, Md.

17. (Burial, cremation, or removal. Which?) Cremation Date thereof..... July 16th, 1948
 Cemetery or crematory..... Cedar Hill Crematorium

Location..... Bethesda, Maryland

18. Funeral director..... Martin W. Hysong Jr.
 Address..... 1300 N. Street, N.W. - WASH. 5, D.C.

19. 7/14 1948 Date rec'd by registrar..... 7pm E. J. B. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 14 1948 at 5-2 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on July 13, 1948

Immediate cause of death..... Acute pneumonia

Due to..... pleurisy left side

Due to..... lung disease

Due to..... chronic cystitis

Due to..... prostate disease

Other conditions..... Chronic Pulmonary

Neophyte

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

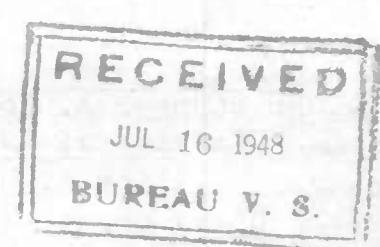
Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... M. D. or other.....

Address..... 2745-29-445 Date signed..... July 14, 1948

RECEIVED
JUL 16 1948
BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07410

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County

Montgomery

Brentsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 54 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

3. (a) FULL NAME

Mary Florence Howard

Now

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Widower

6. (b) Name of husband or wife

Jesse

6. (c) If alive, give age — years

7. Birth date of

deceased (mo., day, yr.) Feb 10 - 1898 - 1872

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Montgomery Co Maryland

(Town, county, and state)

10. Usual occupation.

11. Industry or business

Frisch Waterworks

Mother Father

12. Name

Montgomery Co Maryland

13. Birthplace

Mary & Barnsby Jones

14. Maiden name

Maryland

15. Birthplace

Maryland

16. Informant

Mrs. Bradley in Woodfield

Address

Damascus Md

17. Burial

Date thereof July 3 - 1948

(Burial, cremation, or removal. Which?)

(Month) (day) (year)

(Cemetery or crematory)

St. John's

Location

Brentsville Md

18. Funeral director

Roy G. Parker

Address

Lyonsville Md

19. (Date rec'd by registrar)

1948

Gertrude B. Lawler

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Montgomery

City or town

Brentsville

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 1, 1948, at 2:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep med Evans Case 19 to 19

and that I last saw h... alive on 19

Immediate cause of death

Coronary occlusion

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

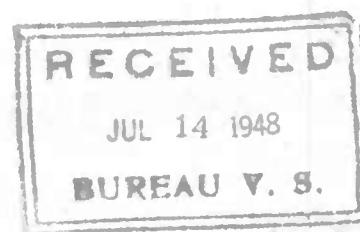
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Frank J. Borschert M.D. or other

Address: 57 Broad St. Date signed: 7-1-48



I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

07411
Reg. Dist. No. 216

CERTIFICATE OF DEATH

1. PLACE OF DEATH: **Montgomery**
County.....

City or town..... **Bethesda (rural)**
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? **2 days**

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? **2 days**

3. (a) FULL NAME

HUNT, Baby Girl

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
female	W-US	

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) **26 July 1948**

8. AGE: Years **1** Months **11** Days **15** If less than one day

9. Birthplace **Bethesda, Maryland (rural)**
(Town, county, and state)

10. Usual occupation.....

11. Industry or business

MOTHER FATHER 12. Name **HUNT, Sanford B., Jr.**

13. Birthplace **N.J.**

14. Maiden name **SMITH, Helen**

15. Birthplace **La.**

16. Informant **fa: Capt. Sanford B. Hunt Jr.**

Address **1142 Arlington Terrace, Alexandria, Va.**

17. **cremation** Date thereof **7-30-48**

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory **Cedar Hill**

Location **Washington, D.C.**

18. Funeral director **Reuben PUMPHREY, Jr.**

Address **7557 Wisconsin Ave., Bethesda, Md.**

19. **7-28 1848** (Date rec'd by registrar) **Mary C. Patterson**
Mary C. Patterson
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State **Virginia** County **Alexandria**

City or town..... (If outside city or town limits, write RURAL and give nearest town)

Street No. **1142 Arlington Terrace, Huntington P.O.**
(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH **28 July** 19 48 at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
26 July 19 48 to **28 July** 19 48
and that I last saw her alive on **28 July** 19 48

Immediate cause of death **Fetal asphyxia**
DURATION **since birth**

Due to **Phenylketonuria**

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results **Same as above**
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE **J. T. FOWLER, Jr., Cdr. MC USN**
M. D. or other

Address **USNH Bethesda, Md.** Date signed **7-28-48**



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

163B

07412 216

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County.....

Montgomery Co.

City or town.....

Chevy Chase, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

2 months.

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Callie Ireland

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white widowed

6. (b) Name of husband or wife.....

Francis Albert

7. Birth date of

deceased (mo., day, yr.)

8. (c) If alive, give age..... years

May - 29 - 1896

8. AGE: Years

Months

Days

If less than one day

52 29 hrs. min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business

Cal Weishart

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof..... (month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. (Date rec'd by registrar)

7/28 1944

7/28/44

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

157 5th St. Anderson, Ind.

County.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

Box 260

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

311-01-0183

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 28 1944, at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Medical Examiner's Case
and that I last saw h..... alive on

Immediate cause of death.....

Barbituric acid
poisoning

Due to.....

(Suicide)

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Suicide Date of

Where did injury occur?.....

(City or town) (County) (State)

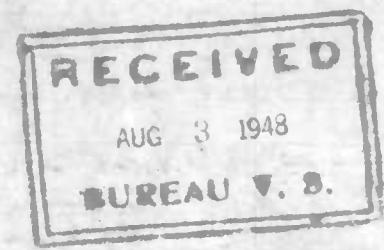
Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

Mildred G. Baersfeld M.D.
sub. dep. Med. Examiner of Anderson Co.
Address..... Bethesda, Date signed 7/28/44



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07414

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
City or town Chevy Chase

How long in above place of death?

Hospital, Institution, or street address where death occurred:

10 Taylor St.

How long in hospital or institution?

3. (a) FULL NAME

Frederick Augustus Ives

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Edith P. Ives

6.(c) If alive, give age.....years

7. Birth date of deceased (mo. day. yr.)

October 4, 1862

8. AGE: Years

85

Months

9

Days

1

If less than one day

hrs.

min.

9. Birthplace

Hamden, Conn.

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

George E. Ives

12. Name

13. Birthplace

Conn.

14. Maiden name

Cornelia Dickerman

15. Birthplace

Conn.

16. Informant

Mrs Blodgett Sage

17. Cremation

Address 10 Taylor St. Chevy Chase, Md.

Date thereof July 8, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Cedar Hill Crematory

Location

Suitland, Prince George Co., Md.

18. Funeral director

Warren E. Pumpelly, Inc.

Address

8434 Ga. Ave., Silver Spring, Md.

19. (Date rec'd by registrar)

7/6 1948

Warren E. Pumpelly
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

Street No. 10 Taylor St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 5, 1948, at 89.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Medical Examiner's Case
and that I last saw h. alive on 19.

Immediate cause of death

Coronary occlusion

Due to

Chr. arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

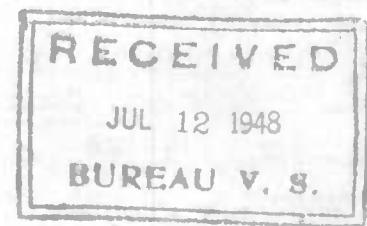
Injured at work?

23. SIGNATURE

Evel G. Bassfield, M.D.
Substitute Deputy Medical Examiner
Address Box 1000, Rockville, Md. Date signed 7/5/48M
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age.I
MARGIN RESERVED FOR BINDING

9-45-15 M

VS A15



Evidence for change of
AGE shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

102

07413

FILE No. G 117 SEP 16 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH:

County

Montgomery

City or town #10 Cabin Johns, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Philip Jackson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

Colored

Married

6. (b) Name of husband

and wife Frances V. Jackson

7. Birth date of deceased (mo., day, yr.)

May 13, 1855

6. (c) If alive, give age years

8. AGE:

Years
93

Months
92

Days
2

If less than one day

hrs. min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation.

11. Industry or business

MOTHER

FATHER

12. Name James Jackson

13. Birthplace

Maryland

14. Maiden name

15. Birthplace

Maryland

16. Informant

Frances V.

Jackson

Address

#10

Cabin Johns, Md.

Burial

17. (Burial, cremation, or removal. Which?)

#10

Cemetery or crematory

Cabin Johns, Md.

Location

Cabin Johns, Md.

18. Funeral director

Robert L. Snodder

Address

Rockville, Md.

19. (Date recd by registrar)

7/31/48

1948

7pm 3 Jules

2. USUAL RESIDENCE (HOME) OF DECEASED:

For newborn infants give residence of mother

State Maryland

County

City or town #10 Cabin Johns, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 29, 1948, at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1, 1948, to July 29, 1948

and that I last saw him alive on July 29, 1948

Immediate cause of death

Cardiac Exhaustion

Due to

Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

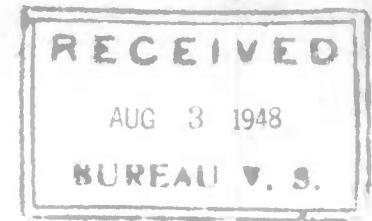
Injured at work?

23. SIGNATURE

M. D. or other

Address

Bethesda, Md. 20204



M. FOR CHANGE OF
MOTHER'S MAIDEN NAME
SHOWN ON FILM NO. G116 - 8-10-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07415

160a

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

Montgomery County

Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 hour

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1 hour

3. (a) FULL NAME

JOHNSON, Baby Girl

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

female

W-US

single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

14 July 1948

8. AGE:

Years

Months

Days

If less than one day

3 hrs. min.

9. Birthplace

Bethesda (rural)

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name JOHNSON, Calvin Arthur

13. Birthplace

FAIRFIELD, Rose

14. Maiden name

Wash., D.C.

15. Birthplace

16. Informant father: Calvin Arthur Johnson

Address 718 11th St., S.E., Wash., D.C.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 7-16-48

(month) (day) (year)

Cemetery or crematory

Arlington National

Location A Arlington, Virginia

DSB

18. Funeral director W.W. Chambers

Address 517 11th St. S.E., Washington, D.C.

19. 7-14 18 48

(Date rec'd by registrar)

Mary J. Patterson

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Slate D.C.

County

Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 718 11th St., S.E.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

14 July

19 48 at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

14 July 1948 to 14 July 1948

and that I last saw her alive 14 July 1948

Immediate cause of death Preterm birth

Anencephalic Mortality

Due to Hematogenous separation of placenta

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

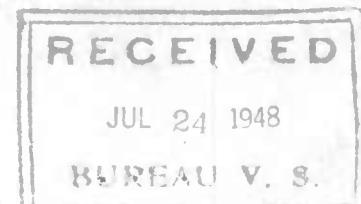
Paul Peterson

Captain MC USN

M. D. or other

Address USNH Bethesda, Md.

Date signed 7-14-48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07416

CERTIFICATE OF DEATH

Reg. Dist. No. 217

170 C

1. PLACE OF DEATH

County

Montgomery

City or town Rockville (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs

Hospital, Institution, or street address where death occurred:

Cloverly md

How long in hospital or institution?

3. (a) FULL NAME

Florence Eva Johnson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white married

6. (b) Name of husband or wife Herbert Johnson

7. Birth date of deceased (mo., day, yr.) Aug 24, 1909

6. (c) If alive, give age 51 years

8. AGE: Years 38 Months 10 Days 23 If less than one day hrs. min.

9. Birthplace Woodstock Va

(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business Home

12. Name Robert E Yowell

13. Birthplace Virginia

14. Maiden name Johnson

15. Birthplace

16. Informant Robert E Yowell

Address Silver Spring md

17. Burial, cremation, or removal. Which? Date thereof July 21, 1948

(Burial, cremation, or removal. Which? Month (day) (year))

Cemetery or crematory Clarksburg, md

Location Howard Co md

18. Funeral director Bob W. Barber

Address Germantown, md

19. Date rec'd by registrar 7-21 1948

(Date rec'd by registrar) 1948 Gertrude B. Lawler

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Monty

City or town Rockville (rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No. Cloverly md

(If rural give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 1948 at 9:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep med Etown care 19. 10. 19. 19.

and that I last saw h alive on 19.

Immediate cause of death

Fracture of 3rd cervical vertebrae

Due to (accidental) 19. 10. 19. 19.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide recent Date of 7/17/48

Where did injury occur? Cloverly Monty md (City or town) (County) (State)

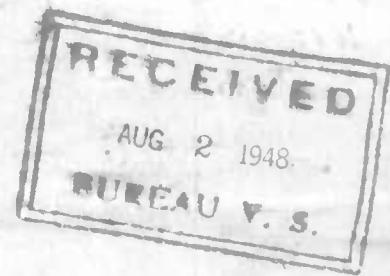
Injured at home, farm, industry, public place (where?) Highway 29

Means of injury Stomach pains Injured at work? No

23. SIGNATURE Frank J. Broschart M. D.

Self and family M. D. or other

Address Germantown, md Date signed 7-17-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07417

CERTIFICATE OF DEATH

93d
Reg. Dist. No. 223

1. PLACE OF DEATH:

County MONTGOMERY Co
City or town TAKOMA PARK MD
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

507 CARROLL AVE.

How long in hospital or institution?

3. (a) FULL NAME

MR HENRY

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County MONTGOMERY
City or town TAKOMA PARK
(If outside city or town limits, write RURAL and give nearest town)
Street No. 507 CARROLL AVE.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

JORG

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

M.W.SINGLE

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) APRIL 11, 1867

8. (c) If alive, give age.....years

8. AGE:

Years 81 Months 3 Days 11 If less than one day
hrs. min.9. Birthplace WASHINGTON, D.C.

(Town, county, and state)

10. Usual occupation FURNITURE FINISHER

11. Industry or business

12. Name HENRY JORG13. Birthplace GERMANY14. Maiden name ANNA SCHMIDT15. Birthplace GERMANY16. Informant CHARLES JORG - BRO.Address 128 UHLAND TERR. N.E. D.C.17. Burial BURIAL Date thereof 7-24-48
(Burial, cremation, or removal. Which?)Cemetery or crematory PROSPECT HILLLocation WASHINGTON, D.C.

18. Funeral director

Address 706 Penn Ave. D.C.19. Date rec'd by registrar JULY 22 1948

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 22nd 1948 at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 17th 1944 to July 22 1948and that I last saw h. alive on May 4th 1948Immediate cause of death cardiomyocardiosis

DURATION

30 daysDue to arteriosclerosis& myocarditisBernardDue to —Other conditions —

(Include pregnancy within 8 months of death)

Major findings of operations —Date of op. —Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

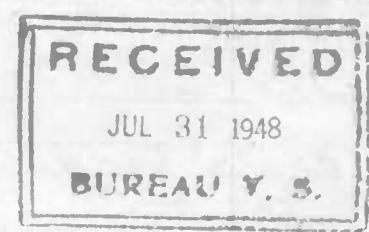
Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) — (County) — (State) —Injured at home, farm, industry, public place (where?) —Means of injury —Injured at work? —

23. SIGNATURE

J. B. Monk of MD

M. D. or other

Address 915-1/2 16th Date signed JULY 22 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

07418

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County... Montgomery

City or town... Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?... 19 days

Hospital, institution, or street address where death occurred:

U.S. Naval Hospital, Bethesda, Maryland

How long in hospital or institution?... 19 days

3. (a) FULL NAME

KIMBROUGH, Robert

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

Negro

widowed

6. (b) Name of husband or wife

6. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) 30, December 1892

8. AGE:

Years	Months	Days	If less than one day
55	7	1	hrs. min.

8. Birthplace... Virginia

(Town, county, and state)

10. Usual occupation... Porter

11. Industry or business

12. Name... Robert Kimbrough Dec.

13. Birthplace... Virginia

14. Maiden name... Julia Mead Dec.

15. Birthplace... Virginia

16. Informant... Daughter, Miss Madalene Kimbrough

Address 1440 S. St. N.W. Wash. D.C.

17. Burial... Cemetery or crematory Arlington National

(Burial, cremation, or removal. Which?) Date thereof... 8-4-48
(month) (day) (year)

Location... Arlington, Va.

18. Funeral director... W. Ernest Jarvis, ✓ E. Jarvis

Address 1432 U. St. N.W. Washington, D.C.

19. 8-1 1948 Mary C. Patterson
(Date Rec'd by registrar) Mary C. Patterson
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... D.C. County...

City or town... Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1440 S. St. N.W.

(If rural, give LOCATION)

2. (a) If veteran, name war... WWI

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH... 31 July

1948 at 03:15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

12 July 1948 to 31 July 1948

and that I last saw h. in alive on 31 July 1948

Immediate cause of death

Clark myocardial failure

DURATION

20 min

Due to... Arterio-venous occlusion
+ hypertensive heart

undet

Due to...

Other conditions... cellulitis at leg

(Include pregnancy within 8 months of death)

Major findings or operations...

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

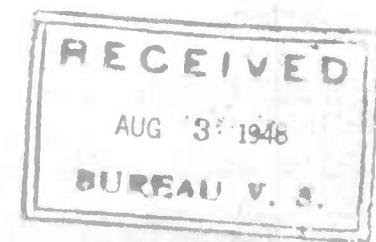
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE... R. C. KESSLER, Lt. JG MC USN
M. D. or other

Address... USNH Bethesda, Md. Date signed... 8-1-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

462

07419

216

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Montgomery

City or town..... Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 1 month, 14 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution?..... 1 month, 14 days

3. (a) FULL NAME

LECHOWICZ, Joseph Francis

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male W-US married

8. (b) Name of husband or wife..... Mary K. Lechowicz

7. Birth date of deceased (mo. day, yr.)..... March 31, 1895

8. AGE: Years Months Days If less than one day
53 3 29 hrs. min.9. Birthplace..... Ohio
(Town, county, and state)10. Usual occupation..... Gasoline Station Owner
Cleveland, Ohio

11. Industry or business

12. Name..... LECHOWICZ, Peter
Poland13. Birthplace..... IDAKIEWIZ, Vincenta
Poland14. Maiden name..... IDAKIEWIZ, Vincenta
Poland

15. Birthplace.....

16. Informant..... Wife: Mrs. Mary K. Lechowicz
Address 524 22nd St., N. W., Wash., D.C.17. Burial..... Date thereof..... 8-3-48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... Arlington National
Location..... Arlington, Va.18. Funeral director..... W. W. CHAMBERS
Address Georgetown, D. C.19. 7-30 1948 Mary C. Patterson
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D.C. County..... Washington

City or town..... (If outside city or town limits, write RURAL and give nearest town)

Street No..... 524 22nd St., N. W. (If rural, give LOCATION)

2. (a) If veteran, name war..... WWI

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 30 July 1948, at 8:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
16 June 1948 to 30 July 1948
and that I last saw him alive on 30 July 1948Immediate cause of death.....
Adenocarcinoma of sigmoid
with Cachexia

Due to.....

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results..... confirmed above Date of op.
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....

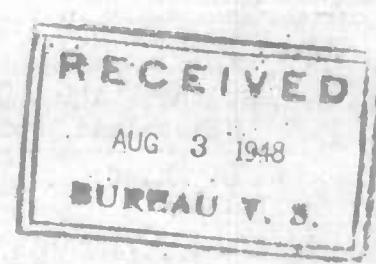
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?
Robert C. KesslerR. C. KESSLER, Lt JG MC USN
23. SIGNATURE..... M. D. or other

Address USNH Bethesda, Md. Date signed 7-30-48

X



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

117a

CERTIFICATE OF DEATH

1174246
Reg. Dist. No. 1

1. PLACE OF DEATH:

County... Montgomery

City or town... Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Mo. 1 Day

Hospital, institution, or street address where death occurred:

U. S. Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1 Mo. 1 Day

3. (a) FULL NAME

MARTIN, Joseph Thomas

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male W - US Married

6. (b) Name of husband or wife... Mary C. Martin

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) 4-10-94

8. AGE: Years Months Days It less than one day
54 3 9 hrs. min.9. Birthplace... New Jersey
(Town, county, and state)

10. Usual occupation... Accountant

11. Industry or business

12. Name... George W. Martin Dec.

13. Birthplace... Germany

14. Maiden name... Mary Tanganyay Dec.

15. Birthplace... Ireland

16. Informant... Mary C. Martin (Wife)

Address 5061 1st St. N.W. Wash. D.C.

17. Burial Date thereof 7-22-48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Arlington National Cemetery

Location... Arlington, Virginia

18. Funeral director... W.W. CHAMBERS R.R.

Address 1400 CHAPIN ST. NW, WASH. D.C.

19. 20 July 1948 Mary C. Patterson
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Dist. of Col. County

City or town... Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5061 1st St. N.W.

(If rural, give LOCATION)

2. (a) If veteran, name war... WWI

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 July 1948 at 0920 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

18 June 1948 to 19 July 1948

and that I last saw him alive on 19 July 1948

Immediate cause of death

Ulcer Stomach Perforated

DURATION

Days ?

Due to... Abscess, left subdiaphragmatic Days ?

Due to...

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. N. SHELLEY CDR MC USN or other

Address USNH, BETHESDA, MD. Date signed 7-1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 94a 0742213

1. PLACE OF DEATH

County

Montgomery

City or town

Glen Echo

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

5 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

William Mason

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

Colored Married

8. (b) Name of husband or wife

Amanda Mason

7. Birth date of deceased (mo., day, yr.)

April 7, 1880

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

Augusta Mason

13. Birthplace

Md

14. Maiden name

Berrianne

15. Birthplace

Md

16. Informant

Amanda, Mason

Address

Lincoln Park Rockville

Burial, cremation, or removal (which?)

Buried

Date thereof (month (day) (year))

Cemetery or crematory

Lincoln Park

Location

Rockville, Md.

18. Funeral director

Robert J. Snodder

Address

Rockville, Md.

19. Date rec'd by registrar

July 6, 1948

19. (Date rec'd by registrar)

E. C. Thompson

T

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Montgomery

City or town

Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Lincoln Park

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

July 1

1948, at 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep med. Elan care

and that I last saw h. alive on

19

19

Immediate cause of death

coronary occlusion

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

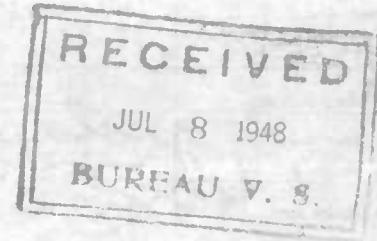
Frank J. Bioschart M.D.

M. D. or other

Address

Gaithersburg, Md.

Date signed 7-11-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line correct if possible. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223-07422

1. PLACE OF DEATH: MONTGOMERY
 County: TAKOMA PARK
 City or town: TAKOMA PARK
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 35 yrs
 Hospital, institution, or street address where death occurred: 1022 FLOWER AVE
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State: MONTGOMERY
 County: MONTGOMERY
 City or town: TAKOMA PARK
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.: 1022 FLOWER AVE
 (If rural, give LOCATION)
 2.(a) If veteran, name war?

3. (a) FULL NAME

FAYETTE GEORGE MATHEWS

3. (b) Social Security Number

NONE

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced MARRIED

6. (b) Name of husband or wife GERTRUDE W. MATHEWS

7. Birth date of deceased (mo. day, yr.) DEC. 2, 1886 6. (c) If alive, give age years

8. AGE: Years 61 Months 7 Days 28 If less than one day hrs. min.

9. Birthplace ROCHESTER N.Y.
 (Town, county, and state)

10. Usual occupation TINNER

11. Industry or business SHEET METAL WORKS

12. Name ROBERT MATHEWS
 13. Birthplace ENGLAND

14. Maiden name UNKNOWN

15. Birthplace 11

16. Informant Mrs. GERTRUDE W. MATHEWS

Address 1022 FLOWER AVE, TAKOMA PARK, MD

17. Burial Burial Date thereof Aug. 5, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington Nat'l Cemetery

Location Arlington, Va.

18. Funeral director J. ARTHUR WALTERS

Address 254 CARROLL ST, TAKOMA PARK, DC

19. Aug. 1, 1948 (Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 30, 1948 at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JUNE 2, 1948 to JULY 30, 1948 and that I last saw h. j. m. alive on JULY 29, 1948

Immediate cause of death Cardiac Failure DURATION few min.

Due to Chronic Myocarditis 1 yr.

Due to Latent Syphilis ?

Other conditions Include pregnancy within 3 months of death

Major findings of operations — Date of op. —

Autopsy results — PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) — (County) — (State) —

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE J. H. McNeill, M.D. D. or other —

Address Silver Spring, Md. Date signed 7/30/48

RECEIVED

AUG 6 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly. Supply every item of information carefully. The correctness is especially important.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 13858
466 x
U7423
296

1. PLACE OF DEATH:

County

City or town

Montgomery

Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution? 2 mos 18 days

3. (a) FULL NAME

Allen C. McCauley

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male white married

6. (b) Name of husband or wife

Dorothy

7. Birth date of deceased (mo., day, yr.)

Feb - 4, 1911 -

6. (c) If alive, give age years

8. AGE:

Years 37 Months 5 Days 25 If less than one day hrs. min.

9. Birthplace

Washington, D.C.

(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

Charles McCauley

12. Name

13. Birthplace

Montgomery Co. Md.

14. Maiden name

Julia Kidwell

15. Birthplace

Washington D.C.

16. Informant

wife

Address

same

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Aug. 2, 1948
(month) (day) (year)

Cemetery or crematory

Washington National Cem.

Location

Baltimore Md.

18. Funeral director

W. W. Chambers Co.

Address

3072 - M. St. N. W.

7/29 1948

(Date rec'd by registrar)

Signature Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Glen Echo (If outside city or town limits, write RURAL and give nearest town)

Street No. 7200 Mass. Ave -

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH July 29, 1948, at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1, 1948, to July 29, 1948, and that I last saw h. l. M. alive on July 29, 1948.

Immediate cause of death

RESPIRATORY FAILURE

DURATION

Due to CARCINOMATOUS INFILTRATION

OF PLEURA WITH EFFUSION

Due to CARCINOMA OF

STOMACH

Other conditions MASSIVE METASTASIS

MEDIASTINAL AND mesenteric LYMPH NODES
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results PENDING

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. Engle

M. D. or other

Address 1828 THE 1828 THE 1828

Date signed July 30

RECEIVED

AUG 3 1948

BUREAU F. B. I.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age
is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07424

46d

FILM NO. G 117 AUG 25 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County..... Montgomery

City or town..... Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 11 months, 19 days

Hospital, institution, or street address where death occurred:..... US Naval Hospital, Bethesda, Md.

How long in hospital or institution?..... 11 months, 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D.C. County.....

City or town..... Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No..... 1115 Chapin St., N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war..... WWI & II

3.(a) FULL NAME

McGIVERIN, Harold William

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	divorced

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)..... March 13, 1903 1902

6.(c) If alive, give age..... years

8. AGE: Years	Months	Days	If less than one day
46	4	12	hrs. min.

9. Birthplace..... Wisconsin
(Town, county, and state)

10. Usual occupation..... unemployed

11. Industry or business

12. Name	McGIVERIN, William
13. Birthplace	Minn.

14. Maiden name	FEATHERSTON, Fannie
15. Birthplace	Minn.

16. Informant	daughter: Mrs. Virginia McG. Broyer
Address	1115 Chapin St., N. W., Wash., D.C.

17. burial	Date thereof
(Burial, cremation, or removal. Which?)	(month) (day) (year)

Cemetery or crematory..... Arlington National

Location..... Arlington, Virginia

18. Funeral director..... W. W. CHAMBERS

Address..... 1100 Chapin St., N. W., Wash., D.C.

19. (Date rec'd by registrar)	7-26-48	main c. Patterson
		Mary C. Patterson Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH..... 25 July 1948 at 10:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6 August 1947 to 25 July 1948 and that I last saw him alive on 25 July 1948.

Immediate cause of death..... Cachexia

Due to..... Adeno carcinoma of rectum

Due to..... extensive metastasis

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results..... Adeno carcinoma rectum & metastases
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

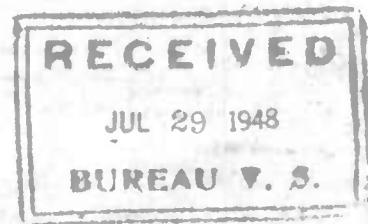
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE	Robert C. Kessler
	R. C. KESSLER, Lt. JG MC USN
	M. D. or other

Address..... USNH Bethesda, Md. Date signed..... 7-26-48



RECEIVED

JUL 12 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The doctor's age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

556

07426
2/14

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

Montgomery

County

Kensington

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

3402 Farragut St.

How long in hospital or institution?

3. (a) FULL NAME

MENS

Frances A. Mens

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Widowed

6. (b) Name of husband or wife

Celeste V. Mens

7. Birth date of deceased (mo., day, yr.)

May 22, 1879

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Zurich Switzerland

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Nicholas Bucker

MOTHER FATHER

12. Name

Nicholas Bucker

13. Birthplace

Switzerland

14. Maiden name

Anna Pfenninger

15. Birthplace

Switzerland

16. Informant

Mrs Richard Bozeman

Address

3402 Farragut St. Kensington

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof July 15, 1948

(month) (day) (year)

Holy Cross

Cemetery or crematory

Philadelphia, Pa.

Location

Warren E. Lumphey, Inc.

18. Funeral director

Address 8434 Ga. Ave. Silver Spring, Md.

19. July 13 1948

Date rec'd by registrar

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Montgomery

City or town

Kensington

(If outside city or town limits, write RURAL and give nearest town)

Street No.

3402 Farragut St.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

7/13/48

19

at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

N N 47

19

to

7/12/48

19

and that I last saw her alive on

Immediate cause of death

Carcinoma

19

1. Spine

2. Chest

Tyr

Due to

Carcinoma

Unknown

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Sam Allen MD

M. D. or other

Address

Kensington, Md. Date signed 7/13/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Measink

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

CERTIFICATE OF DEATH

Reg. Dist. No. 27237

1. PLACE OF DEATH:

County MontgomeryCity or town Telbora Park, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months 3 days

Hospital, institution, or street address where death occurred:

805 Mohe Ave

How long in hospital or institution?.....

3. (a) FULL NAME

Henrietta A. Measink

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

female white widow

6. (b) Name of husband or wife

William

7. Birth date of deceased (mo., day, yr.)

July 3 1867

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Germany

(Town, County, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name Henry Himmelberg13. Birthplace Germany14. Maiden name unknown15. Birthplace "16. Informant Mrs. Marie A. WestAddress 1205 6th N.E. Wash. D.C.17. Burial (Burial, cremation, or removal. Which?)Date thereof 7/7/48

(month) (day) (year)

Cemetery or crematory St. Marys CemeteryLocation Washington D.C.18. Funeral director Frank Leers Sons CoAddress 3605-14 st NW Wash. D.C.19. July 5 1948 (Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Wash. D.C. County

City or town..... (If outside city or town limits, write RURAL and give nearest town)

Street No. 1205 6th N.E.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 1948 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 3 1948 to July 4 1948and that I last saw her alive on July 4 1948

Immediate cause of death

Acute Cardiac FailureDue to Arteriosclerotic heart disease with Chronic nephritis and uremia

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

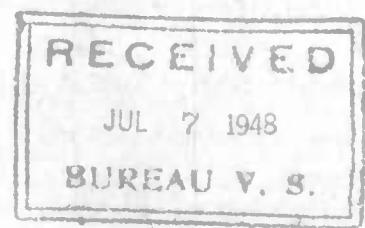
Means of injury

Injured at work?

23. SIGNATURE Rean D. Hardin MD

M.D. or other

Address 113 Carroll St NW Date signed 7/14/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

07428

Reg. Dist. No. 223

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month

Hospital, Institution, or street address where death occurred:
Washington San. & Hospital

How long in hospital or institution? 1 month

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 11149 Viers Mill Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

MONK Eleanor G. Monk

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Thomas O. Monk

7. Birth date of deceased (mo., day, yr.) July 28, 1877

8. AGE: Years 70 Months 11 Days 29 If less than one day
hrs. min.

9. Birthplace Bristow, Virginia
(Town, county, and state)

10. Usual occupation none

11. Industry or business

12. Name Edmond P. Gaines
13. Birthplace Bristow, Va.

MOTHER FATHER
14. Maiden name Martha Davis
15. Birthplace Bristow, Va.

16. Informant Hosp. Records

Address Burial

17. (Burial, cremation, or removal. Which?) Date thereof July 29, 1948
(month) (day) (year)

Cemetery or crematory Rock Creek
Location Washington, D.C.

18. Funeral director Warren E. Pumphrey, Inc.

Address 8434 Ga. Ave. Silver Spring, Md.

19. July 28, 1948 (Date rec'd by registrar)

Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/27/48 19..... at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/27/47 19..... to 7/27/48 19..... and that I last saw her alive on 7/26/48 19.....

Immediate cause of death Congestive Heart Failure 2 months DURATION

Due to Arteriosclerosis 1/2 yrs

Due to Cardiac Hypertrophy 1/2 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

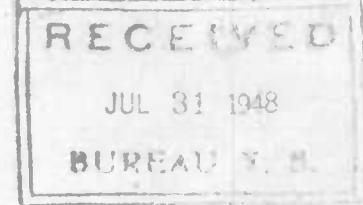
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John Allen MD M. D. or other

Address Pennington Date signed 7/21/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

183

07429

217

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County

Montgomery
Rural Brighton, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Ernest M. Montgomery

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

white, married

6. (b) Name of husband or wife

Ethel May Montgomery

7. Birth date of deceased (mo., day, yr.)

Nov 7 - 1903

8. (c) If alive, give age

years

8. AGE:

Years Months Days It less than one day
44 8 3 hrs. min.

9. Birthplace

Virginia

(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

Homes

12. Name

Otto C. Montgomery

13. Birthplace

Virginia

14. Maiden name

Lillian Montgomery

15. Birthplace

Virginia

16. Informant

Mrs. Ethel May Montgomery

Address

Brighton, Md.

17. Burial

Date thereof July 13 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Lafayetteville, Md.

Location

Montgomery Co. 2nd

18. Funeral director

Roy W. Barber

Address

Lafayetteville, Md.

19. (Date rec'd by registrar)

1948 Gertrude B. Lawler

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 10 1948, at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 26 (Year) 1948, to 1948, to 1948

and that I last saw him alive on

Immediate cause of death

Asphyxia due to drowning
(accident)

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

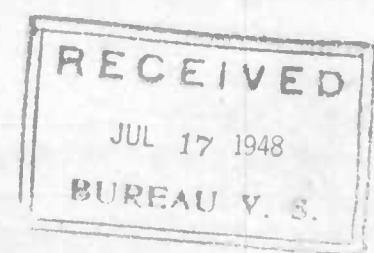
22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. accident Date of 7/10/48Where did injury occur? Brighton, Md. (City or town) (County) (State)injured at home, farm, industry, public place (where?) farmMeans of injury drowning Injured at work? no

23. SIGNATURE

Frank J. Brochart, M.D. M. D. or other

Signature Frank J. Brochart, M.D. Date signed 7/11/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

456

09430

CERTIFICATE OF DEATH

216

Reg. Dist. No.

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Mo 11 Days

Hospital, institution, or street address where death occurred:

U. S. Naval Hospital, Bethesda, Md.

How long in hospital or institution? 2 Mo. 11 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia

County

City or town R #1 Beaverdam

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

3. (a) FULL NAME

MOYNIHAN, Cornelius Dennis

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	W-U.S.	Married

6. (b) Name of husband or wife Myrtle H. Moynihan

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-6-87

8. AGE: Years	Months	Days	If less than one day
60	9	8	hrs. min.

9. Birthplace Washington, D. C. (Town, county, and state)

10. Usual occupation Automobile salesman

11. Industry or business

12. Name Joseph C. Moynihan Dec.

13. Birthplace Washington, D. C.

14. Maiden name Cathrine Reichert Dec.

15. Birthplace Washington, D. C.

16. Informant Wife: Mrs Myrtle H. Moynihan

Address Rt #1, Beaverdam, Virginia

17. Burial Date thereof 7-16-48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Prince George Co., Maryland

Mt. Airy Co. Ga.

18. Funeral director S. H. Hines

Address 2901 14th St. N.W. Washington, D.C.

7-14-48

(Date rec'd by registrar)

Mary C. Patterson

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 July 1948, at 07:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3. May 1948, to 14 July 1948, and that I last saw him alive on 14 July 1948.

Immediate cause of death Cachexia due to carcinoma of tongue

Due to metastatic carcinoma of liver

Due to General arteriosclerosis

Other conditions Patent foramen ovale

Hyperplasia prostate, etc.

(Include pregnancy within 3 months of death)

Major findings Operations

Autopsy results Cachexia due to carcinoma

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?)

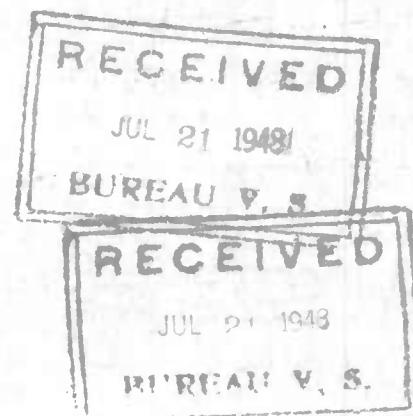
Means of injury Injured at work?

A. J. DELANEY, Capt. MC USN

23. SIGNATURE M. D. or other

USNH Bethesda, Md. Date signed 7-14-48

Address



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

07431
214

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County

Montgomery

City or town

8379 #12 Silver Spring, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution? Since August 9, 1947

3. (a) FULL NAME

Mrs Sallie D. Nye

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Widowed

6. (b) Name of husband or

John B. Nye

7. Birth date of deceased (mo., day, yr.)

May 1 1855

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

93

2

26

hrs.

min.

9. Birthplace

Lerry Township, Dauphin Co.

(Town, county, and state)

Penn.

10. Usual occupation

House wife

11. Industry or business

Absalon Blessing

MOTHER FATHER

12. Name

Name

Dauphin Co. Penn.

13. Birthplace

Polly Daub

14. Maiden name

Bengt

15. Birthplace

Name

Frank Nye (Son)

16. Informant

Name

23 V Street N. E.

Address

Name

17. Burial

Name

Date thereof July 29, 1948

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Name

Cemetery or crematory

Name

Location

Name

18. Funeral director

Name

Address

Name

Name

19. Date rec'd by registrar

Name

Josephine Schaeffer

Name



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07432

CERTIFICATE OF DEATH

93d Reg. Dist. No. 218

1. PLACE OF DEATH:

County Montgomery
 City or town Olney Maryland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital, Inc.

How long in hospital or institution?

3. (a) FULL NAME

Arthur Marvin Plummer

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6. (b) Name of husband or wife	Mrs. Mary E. Plummer	
--------------------------------	----------------------	--

7. Birth date of deceased (mo., day, yr.)	July 20, 1884	
---	---------------	--

8. AGE: Years	Months	Days	If less than one day
64	0	1	hrs. min.

9. Birthplace	Goshen, Maryland	
---------------	------------------	--

(Town, county, and state)

10. Usual occupation	Merchant	
----------------------	----------	--

11. Industry or business		
--------------------------	--	--

12. Name	Marvin E. Plummer	
----------	-------------------	--

13. Birthplace	Laytonsville, Md.	
----------------	-------------------	--

14. Maiden name	Alice Cleggatt	
-----------------	----------------	--

15. Birthplace	Darnestown, Md.	
----------------	-----------------	--

16. Informant	Hospital Records	
---------------	------------------	--

Address

17. Burial	Date thereof	7/23/48
------------	--------------	---------

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory	Forest Oak Cemetery	
-----------------------	---------------------	--

Location	Gaithersburg, Md.	
----------	-------------------	--

18. Funeral director	Forest Oak Cemetery	
----------------------	---------------------	--

Address	Gaithersburg, Md.	
---------	-------------------	--

19. Date rec'd by registrar	July 23, 1948	
-----------------------------	---------------	--

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Gaithersburg (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1948 at 7:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 9 1948 to July 20 1948and that I last saw h.e. in alive on July 20 1948

Immediate cause of death

Coronary ThrombosisDue to 24 per centuric arteria -
sclerotica Heart Disease

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

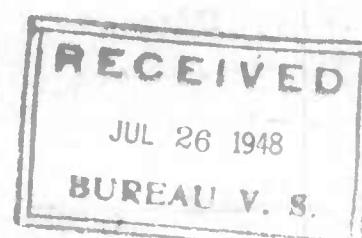
Injured at work?

23. SIGNATURE

Gordon S. Rosenberg, M.D.

(D. or other)

Address Bethesda, Maryland Date signed 7/21/48





The correct age

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The causes of death clearly and legibly.

VS A15 9-45-15 M

is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07433

131a

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital

How long in hospital or institution?

8 days

3. (a) FULL NAME

Mr. Thomas Pritchard

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Widowed

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 20, 1874

8. AGE:

Years

Months

Days

If less than one day

74

1

0

hrs.

min.

9. Birthplace Fairmont, West Virginia

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Henry Pritchard13. Birthplace West Virginia14. Maiden name Sarah Malee15. Birthplace West Virginia16. Informant Hospital records

Address

17. Burial Burial Date thereof 7-24-48
(Burial, cremation, or removal, when)
(month) (day) (year)Cemetery or crematory Prospect X
Location Mt. airy, Frederick Co. Md.18. Funeral director B. M. WallAddress Winfield, Md.19. 7-21 1948 Registrars
(Date rec'd by registrar) Bertrand B. Lawler

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Montgomery

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1948 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 1947 to July 20 1948and that I last saw him alive on July 20 1948

Immediate cause of death

Candida failure

DURATION

2 weeksDue to Candida failure same diseaseinflammation

2 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

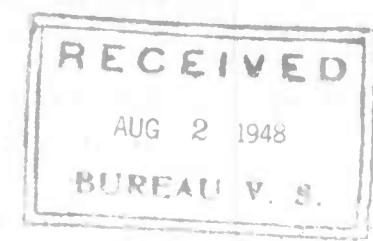
Injured at work

23. SIGNATURE

John K. Anderson, Dyer, M.D.

M.D. or other

Address 7110 Anacostia, D.C. Date signed 7/21/48



PLEASE WRITE PLAINLY, WITH INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07434

216

CERTIFICATE OF DEATH

462
Reg. Dist. No.

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 43 days

Hospital, institution, or street address where death occurred:

U. S. Naval Hospital, Bethesda, Md.

How long in hospital or institution? 43 days

3. (a) FULL NAME

Thomas Wendell QUEEN

3. (b) Social Security Number

4. Sex Male 5. Color or race C- U.S. 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Helen Queen

6. (c) If alive, give age years

7. Birth date of deceased (mo. day. yr.) 7 July 19258. AGE: Years 23 Months 0 Days 2 If less than one day hrs. min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Janitor at Polish Embassy

11. Industry or business

12. Name Henry Queen13. Birthplace Maryland14. Maiden name Helen Smith15. Birthplace Washington, D.C. DEC16. Informant Wife: Helen QueenAddress 486 L St. S.W. Washington, D.C.17. Burial Burial Date thereof 7-13-48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Arlington National CemeteryLocation Arlington, Virginia18. Funeral director W. Ernest Jarvis M. E. B.Address 1432 U St., NW, Washington, D.C.19. 7-9 1948
(Date rec'd by registrar) Mary C. Patterson
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Columbia County CountyCity or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 486 L St. S.W. Washington D.C.

(If rural, give LOCATION)

2. (a) If veteran, name war WW 2

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 July 1948 9 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 26 1948 to 9 July 1948 and that I last saw her alive on 9 July 1948.Immediate cause of death Carcinoma, Metastatic ColonDURATION
10 Mo.Due to Intestinal Obstruction and Bronchial Pneumonia, bilateral DaysDue to Terminal

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Confirmed above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

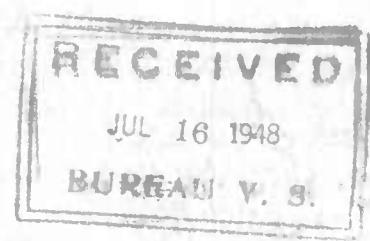
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE R. N. SHELLEY, CDR, MC, USN
M. D. or otherAddress USNH Bethesda, Md. Date signed 7-9-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07435

CERTIFICATE OF DEATH

30g
Reg. Dist. No. 213

1. PLACE OF DEATH

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Isaac Reddick

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

Colored

Widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

May 2, 1882

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Virginia

(Town, county and state)

10. Usual occupation

Janitor

11. Industry or business

MOTHER FATHER

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden name

Sarah

15. Birthplace

Va.

16. Informant

Hortense Shirley

Address

N. Wash. St. Rockville, Md.

17. Burial

Burial

Date thereof July 25, 1948

(Burial, cremation, or removal. Which?) (month, day) (year)

Cemetery or crematory

Lincoln Park

Location

Rockville, Md.

18. Funeral director

Robert F. Snyder

Address

Rockville, Md.

19. (Date rec'd by registrar)

7/25 1948 Mrs. E. P. Thompson

(Date rec'd by registrar)

J. S. G. Bandit

Registrar

7. USUAL RESIDENCE (HOME) OF DECEASED

For newborn infants give residence of mother

State

Montgomery

County

Rockville

City or town

119 N. Washington St.

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 22.

1948 10:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1940 to July 22, 1948

and that I last saw him alive on

Immediate cause of death

Congestive heart failure 1 M.

Due to

Pontic Rupture 105

Due to

Sept. 1, 1948

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

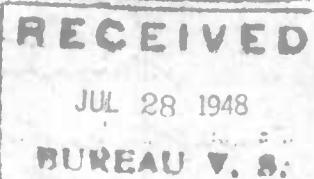
23. SIGNATURE

Willie Walsh
Rockville

M. D. or other

Address

Date signed



I

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

82

07436

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
 County..... Montgomery
 City or town..... Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 Mo 16 Days
 Hospital, institution, or street address where death occurred:
 U. S. Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 6 Mo. 16 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Dist. of Col. County.....
 City or town..... Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 907 Varmum St., N.W.
 (If rural, give LOCATION) ✓
 2.(a) If veteran, name war..... WWI

3. (a) FULL NAME
 RICHMOND, John (n)
 4. Sex..... 5. Color or race..... 6.(a) Single, married, widowed, or divorced
 Male W-U.S. Married
 6.(b) Name of husband or wife..... Loretta Richmond
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) 2-13-89
 8. AGE: Years Months Days If less than one day
 59 5 1 hrs. min.
 9. Birthplace..... England
 (Town, county, and state)
 10. Usual occupation..... Restaurant Manager
 11. Industry or business

MOTHER FATHER
 12. Name..... Richmond Dec.
 13. Birthplace..... England

MOTHER FATHER
 14. Maiden name..... Hannah Green Dec.
 15. Birthplace..... England

16. Informant..... Wife: Mrs. Loretta Richmond

Address 907 Varmum St. N.W. Wash. D.C.
 17. Burial..... Date thereof..... 9-19-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Arlington National

Location..... Arlington, Virginia

18. Funeral director..... T. Hanlon (H)

Address 3831 Georgia Ave. N.W. Wash. D.C.

7-14 48 Mary C. Patterson
 (Date rec'd by registrar) Registrars

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-14 July 1948 at 04:50 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 Dec. 29 1948 to 14 July 1948
 and that I last saw him alive on 14 July 1948

Immediate cause of death..... Amyotrophic lateral sclerosis
 DURATION 3 yrs.

Due to.....

Due to.....

Other conditions.....
 (Include pregnancy within 8 months of death)

Major findings of operation..... Date of op.

Autopsy results..... Confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... C. SAVAGE L115 MC USN M. D. or other

Address..... USNH Bethesda, Md. Date signed 7-14-48

RECEIVED
JUL 21 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07437
216

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... **Montgomery**
City or town..... **Bethesda (rural)**

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... **10 months, 6 days**

Hospital, institution, or street address where death occurred:

U. S. NAVAL HOSPITAL, Bethesda, Md.How long in hospital or institution?..... **10 months, 6 days**

3. (a) FULL NAME

RIDER, Henry Swift4. Sex **Male** 1 5. Color or race **W-US** 6.(a) Single, married, widowed, or divorced
married6.(b) Name of husband or wife..... **Mrs. Chloe Rider**7. Birth date of deceased (mo., day, yr.) **January 22, 1900** 6.(c) If alive, give age years8. AGE: Years **48** Months **5** Days **12** If less than one day hrs. min.9. Birthplace..... **Nebraska** (Town, county, and state)10. Usual occupation..... **unknown**

11. Industry or business

12. Name..... **RIDER, Charles D.** dec. 13. Birthplace..... **Iowa**14. Maiden name..... **SMITH, Minnie,** dec. 15. Birthplace..... **Iowa**16. Informant..... **wife: Mrs. Chloe Rider**Address **211 East Luray Ave., Alexandria, Va.** 17. burial Date thereof..... **7-7-48**
(Burial, cremation, or removal. Which?) **Arlington National Cemetery**

Cemetery or crematory

Location..... **Arlington, Va.**18. Funeral director..... **N. W. CHAMBERS SONS**Address **1400 Chapin St., NW, Wash., D.C.** *J.R.*19. **7-4-48** **Y** **Many C. Patterson**
(Date rec'd by registrar) **Many C. Patterson**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... **Virginia** County.....City or town..... **Alexandria** (If outside city or town limits, write RURAL and give nearest town)Street No..... **211 East Luray Avenue** (If rural, give LOCATION)2.(a) If veteran, name war..... **WWI**

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH..... **4 July** 19. **48**, at **2:07 P.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

28 August 19. **47** to **4 July** 19. **48**and that I last saw him alive on **4 July** 19. **48**

Immediate cause of death

Tuberculosis, Meningeal

DURATION

10 Mo.

Due to.....

Due to.....

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

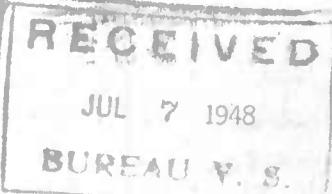
Means of injury

Injured at work?

23. SIGNATURE..... **W. F. Queen**
W. F. QUEEN, Cdr., MC USN

M. D. or other

Address..... **USNH Bethesda, Md.** Date signed **7-4-48**



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF STILLBIRTH

BIRTH AND DEATH
160c Reg. Dist. No. 217

A certificate must be filed within 24 hours for every still birth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:

County Montgomery

City or town Olney, Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street address, hospital, or institution:

The Montgomery Co Gen Hospt

Length of mother's stay in County
(How many years, or months, or days. SPECIFY WHICH)

3. Name of child Robertson

5. Sex Female | 6. Twin or triplet —

FATHER OF CHILD

8. Full name James Henry Robertson

9. Color White 10. Age at time of this birth 42 yrs.

11. Usual occupation habover - Farm

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 3
(b) How many other children were born alive but are now dead? 2 (c) How many other children were born dead? 2

17. Did child die before labor? No During labor? No

18. Pregnancy, complications of Premature
Separation of placenta

19. Labor: (a) Complications of None
(b) Induced? No

20. (a) Was there an operation for delivery? No
(b) State all operations, if any —

(c) Did child die before operation? —
During operation? —

23. (a) Burial (b) Date thereof July 10 - 48
(Burial, cremation or removal) (month) (day) (year)
(c) Cemetery or crematory Layhill

24. (a) Funeral director James H. Robertson
(b) Address Layhill (father)

2. USUAL RESIDENCE OF MOTHER:

State Maryland

County Montgomery

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. R#1 Bay Hill
(If RURAL give LOCATION)

4. Date of birth July 9 1948 Hour 5:10 P.M.

7. No. of weeks pregnancy 28 weeks

MOTHER OF CHILD

12. Full maiden name Depsa Bertha Smith

13. Color White 14. Age at time of this birth 29 yrs.

15. Usual occupation Housewife

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes Prematurity - weight 1 lb 8 oz

(b) Maternal causes 4th delivery at 6 or 7 months gestation

22. I certify to the birth of this child who was born dead* on the date and hour above stated.

Signature G. H. Brown, M.D.
(Specify if M. D., midwife, or other)

Address Sandy Spring, Md.

25. (a) July 9 - 48 (b) Gertude B. Hawley
(Date rec'd by registrar) (Registrar)

26. (To be filled out if no physician was present at delivery.)
The above certificate has been examined by me.

Health Officer, per

RECEIVED
JUL 17 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07439

216

CERTIFICATE OF DEATH

Reg. Diat. No. 136

1. PLACE OF DEATH:

County..... Montgomery

City or town..... Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 1 month, 27 days

Hospital, Institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution?..... 1 month, 27 days

3. (a) FULL NAME

SCOTT, Edward

4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced

male Col married

6. (b) Name of husband or wife..... Maude Scott

6. (c) If alive, give age..... years

7. Birth date of deceased (mon. day, yr.)..... July 15, 1894

8. AGE: Years..... 54 Months..... 0 Days..... 14 It less than one day..... hrs..... min.....

9. Birthplace..... Washington, D. C. (Town, county, and state)

10. Usual occupation..... unknown

11. Industry or business.....

MOTHER FATHER 12. Name..... SCOTT, ? 13. Birthplace..... Washington, D.C.

14. Maiden name..... Rose ? dec. 15. Birthplace..... Washington, D.C.

16. Informant..... wife: Mrs. Maude Scott Address..... 2205 14th St., N. W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof..... 8-2-48 (month) (day) (year)

Cemetery or crematory..... Arlington National Location..... Arlington, Va.

18. Funeral director..... W. Ernest Jarvis Address..... 1432 U St., N. W., Wash., D.C.

19. 7-30-1948 Mary C. Patterson (Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D.C. County.....

City or town..... Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 2205 14th St., N. W.

(If rural, give LOCATION)

2. (a) If veteran, name war..... WW I

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH..... 29 July 1948, at 8:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 June 1948, to 29 July 1948

and that I last saw h. im. alive on 29 July 1948

Immediate cause of death

Tuberculosis, Pulmonary, Rein- fected, Active, Far advanced

Due to.....

Due to.....

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results..... confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

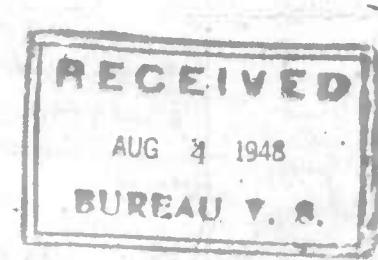
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... W. F. Queen Wm. F. Queen, Cdr. MC USN

M. D. or other

Address..... USNH Bethesda, Md. Date signed..... 7-30-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Reg. Dist. No. 0749423

CERTIFICATE OF DEATH

93d

1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, institution, or street address where death occurred:

6839 Eastern Avenue

How long in hospital or institution?

3. (a) FULL NAME

MISS MABEL SMART.

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

None

6. (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.)

February 14, 1880

8. AGE:

Years 68Months 5Days 3

If less than one day

hrs. 0min. 0

9. Birthplace

Kings, Illinois

(Town, county, and state)

10. Usual occupation

At Home

11. Industry or business

MOTHER FATHER

12. Name Nelson Smart13. Birthplace New York14. Maiden name Harriet Miller15. Birthplace Vermont16. Informant Mrs. Harriet RossAddress 252 Walnut St. NW

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof July 19, 1948

(month) (day) (year)

Cemetery or crematory Fort Lincoln CemeteryLocation Bladensburg Rd. at Blad. Line18. Funeral director Arthur WaltersAddress 254 Capone St. NW, Takoma Park, D.C.19. 7/17

1948

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md

County

MontgomeryCity or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6839

Eastern Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

July 17, 1948 at 10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

now 4, 1945 to July 17, 1948and that I last saw her alive on July 16, 1948

Immediate cause of death

Chronic myocarditis Indirect

Due to

arterio sclerosis

DURATION

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

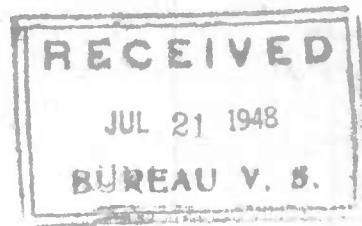
23. SIGNATURE

Dr. Blatt, M.D.

M.D. or other

Address

6911 5th St. N.W. Date signed 7/17/48



PLEASE WRITE PLAINLY, WITH LEADING-INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

0744212

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Montgomery
 City or town Brooksville R.R. 10
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution? _____

3. (a) FULL NAME

Oliver

4. Sex <u>m</u>	5. Color or race <u>W</u>	6. (a) Single, married, widowed, or divorced <u>Single</u>
-----------------	---------------------------	--

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo. day, yr.) 1878 ?8. AGE: Years 70 ? Months _____ Days _____ If less than one day hrs. _____ min. _____9. Birthplace Frederick Co. Md.
 (Town, county, and state)10. Usual occupation Barber

11. Industry or business

12. Name Henry Soper
 13. Birthplace Md.14. Maiden name Mollie Baker
 15. Birthplace Md.16. Informant Henry E. Soper
 Address Brooksville Md. R.R. 1017. Burial Burial Date thereof 7-27-48
 (Burial, cremation, or removal. Which?) Date (month) (day) (year)Cemetery or crematory Monocacy
 Location Bethelville Md.18. Funeral director Wm. B. Hilton
 Address Bethelville Md.19. Date rec'd by registrar July 26 1948 Frank J. Broschart M.D.
 (Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Brooksville R.R. 10
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number Soper none

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1948 at 1:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep. med. Exam cases to 19
 and that I last saw h alive on 19

Immediate cause of death

Coronary occlusion long dead

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

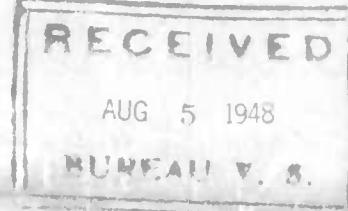
Means of injury Injured at work?

23. SIGNATURE Frank J. Broschart M.D.
Dep. med. Exam. D. or otherAddress Southbury Md. Date signed July 26 1948

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH INK. Supply every item of information
is especially important. Physicians: please write the causes of deaf^h



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1246

07442

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 21 days

Hospital, institution, or street address where death occurred:

Washington Sanitarium & HospitalHow long in hospital or institution? 21 days

3. (a) FULL NAME

Stoner, Mrs. Grace4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Ralph K. Stoner7. Birth date of deceased (mo., day, yr.) Dec. 17, 18908. AGE: Years 57 Months 7 Days 1 If less than one day hrs. 00 min. 009. Birthplace Elbridge, New York
(Town, county and state)10. Usual occupation Clerk - Stenographer11. Industry or business Reconst. Finance12. Name Clarence Cook13. Birthplace New York14. Maiden name Cornelia Morgan15. Birthplace Virginia16. Informant Washington Sanitarium RecordsAddress Takoma Park, Md.17. Burial Date thereof July 21, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Elbridge CemeteryLocation Elbridge, New York18. Funeral director Warren E. Lumpsherry, Inc.Address 8434 Ga. Ave. Silver Spring, Md.19. Date rec'd by registrar July 19, 1948

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)Street No. 6 Midhurst Road
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18, 1948 at 1:50 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 24, 1948 to July 18, 1948, and that I last saw her alive on July 1st, 1948.

Immediate cause of death

Chronic heart of liver

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation Gall Stones, Enlarged cympholic liver
Date of op. 7/12/48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Howard & MorebyM. D. or other
Address 28 Carroll Ave, Takoma Park, Md. Date signed July 18, 1948

RECEIVED
JUL 21 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07443

213

CERTIFICATE OF DEATH

73d
Reg. Dist. No.

1. PLACE OF DEATH:

County

City or town

Montgomery

Rockville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

9 months

Hospital, Institution, or street address where death occurred:

City Hall

How long in hospital or institution?

None

3. (a) FULL NAME

ELIZABETH L. SUNDAY

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Widowed

6. (b) Name of husband

Jacob Glasser

7. Birth date of deceased (mo., day, yr.)

Unknown 1862

8. (c) If alive, give age

Dec

years

8. AGE:

Years
86

Months

86

Days

0

If less than one day

hrs. min.

9. Birthplace

Hamburg, Penna

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

Jacob Smith

13. Birthplace

Penns.

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Esmond K. Sunday

Address

6750 Fairfax Rd, Bethesda, Md.

Cremation

July 6, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Cedar Hill Crematory

Location

Washington, D. C.

18. Funeral director

Wm. Landon Thompson

Address Bethesda, Maryland

19. Date rec'd by registrar

July 6, 1948

(Date rec'd by registrar)

E.P. Thompson

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State New Jersey

County Monmouth

City or town Ashbury Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. unknown

(If rural, give LOCATION)

2.(a) If veteran, name war

No

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 5

1948 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 1948 to July 5, 1948

and that I last saw her alive on

July 3, 1948

Immediate cause of death

{ myocardial failure

Due to

Due to

Other conditions

sphincter relaxation

1 year

(Include pregnancy within 3 months of death)

Major findings or operations

none

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H. L. Thompson, M.D.

M. D. or other

Address Rockville, Md. Date signed July 6, 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age. Especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07444

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 days

Hospital, institution, or street address where death occurred:

Washington Sanitarium & Hospital

How long in hospital or institution? 7 days

3. (a) FULL NAME

Terry, Mrs. Nannie Lee

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white widowed

6. (b) Name of husband or wife Henry L. Terry7. Birth date of deceased (mo., day, yr.) 5-13-758. AGE: Years 73 Months 2 Days 11 If less than one day hrs. min.9. Birthplace Abington, Virginia
(Town, county, and state)10. Usual occupation none11. Industry or business none12. Name Adam Jefferson13. Birthplace Virginia14. Maiden name Sarah Fudge15. Birthplace Virginia16. Informant Washington San. & Hosp. RecordsAddress Takoma Park, Maryland17. Bernard (Burial, cremation, or removal, Which?) Date thereof July 24, 1945 (month) (day) (year)Cemetery or crematory Alexandria VaLocation 7th & Columbia18. Funeral director Alex. J. of J. H. D.Address Alex. J. of J. H. D.19. July 24, 1945 (Date rec'd by registrar) J. H. D. (Signature) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Cherry Chase

(If outside city or town limits, write RURAL and give nearest town)

Street No. 325 High St.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24, 1945 at 7:00 A.M.

21. CERTIFY that death occurred on the date above stated, that attended deceased from

July 17, 1945 to July 24, 1945and that I last saw her alive on July 23, 1945 to July 24, 1945

Immediate cause of death

Coronary ThrombosisDue to Arteriosclerotic Heart diseaseDue to Generalized Arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

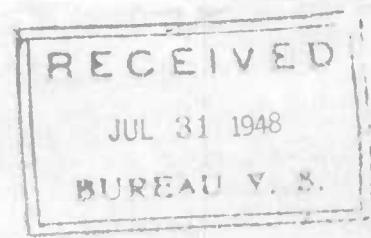
Means of injury

Injured at work?

23. SIGNATURE Dr. Val K. Meade M. D.

M. D. or other

Address Takoma Park, Md. Date signed July 24, 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and legibly. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07445

CERTIFICATE OF DEATH

Reg. Distr. No. 216

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? D.O.A.
Hospital, institution, or street address where death occurred: Suburban Hospital

How long in hospital or institution? Dead on arrival

3. (a) FULL NAME

Milton H Thomas

4. Sex M 5. Color or race col 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife MARIE Woods Thomas

7. Birth date of deceased (mo., day, yr.) August 8, 1916 6. (c) If alive, give age 29 years

8. AGE: Years 31 Months Days If less than one day hrs. min.

9. Birthplace GLADSTONE, VIRGINIA
(Town, county, and state)

10. Usual occupation Assembler

11. Industry or business Capitol Transit Company

12. Name HENRY W. Thomas

13. Birthplace VIRGINIA

14. Maiden name Cora Carpenter

15. Birthplace Amherst, Va.

16. Informant Wife MRS. MARIE W. Thomas

Address 1722 H. STREET N.E. Wash. D.C.

17. Burial Burial Date thereof 7/2/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Woodlawn Cemetery

Location Wash. D.C.

18. Funeral director Hall Bros. Funeral Home

Address 621 Flan. Ave. NW

19. 7/2/48 1948 Wm E. Johnson
(Date read by registrar) (Signature) (Registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington, D.C. County Washington, D.C.
City or town Washington, D.C. (If outside city or town limits, write RURAL and give nearest town)
Street No. 1722 H. STREET N.W., WASH. D.C.
(If rural, give LOCATION) 2. (a) If veteran, name war W.W. II

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2-1948 at 1:00 p.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Medical Examiner's Case and that I last saw him alive on 1948.

Immediate cause of death

Penetrating - great vessels of head

Due to Penetrating wound of head

Due to Penetrating wound of head - Holding spike while working on railroad - use of spike hammer
Other conditions break off a nail in nail of victim.

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

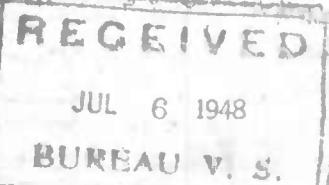
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of July 2, 48

Where did injury occur? Seneca, Montgomery Co., Md. (City or town) (County) (State)

Injured at home, on way, industry, or place (where?) Industry
Means of injury Penetrating wound of head Injured at work? Yes

23. SIGNATURE Eric J. Bauerfield, M.D.
Sub. legally married woman for John C. Bauerfield
Address Bethesda, Md. Date signed 7/2/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

161c

07440

Reg. Dist. No.

1. PLACE OF DEATH

County MontgomeryCity or town Gaithersburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? lifeHospital, Institution, or street address where death occurred: How long in hospital or institution?

3. (a) FULL NAME

Edith Priscilla Trout

3. (b) Social Security Number

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced single8. (b) Name of husband or wife: 7. Birth date of deceased (mo., day, yr.) July - 19 - 48 8. (c) If alive, give age — years8. AGE: Years — Months — Days — If less than one day 15 hrs. — min.9. Birthplace Gaithersburg Md. (Town, county, and state)10. Usual occupation: Housewife11. Industry or business: 12. Name Henry T. Trout13. Birthplace Montgomery Co. Md.14. Maiden name Bethelah C. Trout15. Birthplace Allegheny Co. Md.16. Informant: Bethelah C. TroutAddress Gaithersburg, Md.17. Burial Burial Date thereof July 21 - 48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Lutheran CemeteryLocation Redland, Md.18. Funeral director Dixie BarberAddress Saylorsville, Maryland19. July 21 1948 Alfred G. Cook
(Date signed by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.County MontgomeryCity or town Gaithersburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. Front

(If rural, give LOCATION)

2.(a) If veteran, name war:

MEDICAL CERTIFICATION

20. DATE OF DEATH July - 20 - 1948 at 7 A.M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July - 19 - 1948 to July - 20 - 1948and that I last saw her alive on July 20 - 1948Immediate cause of death: Severe Q. abdominal and headand 3 weeks after neck.Due to: Hydrocephalus &Due to: Other conditions: Huge placenta - partia3 or 4 path

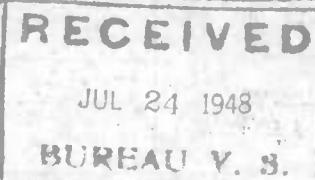
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op. Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of Where did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE William S. Heller, M.D.M. D. or other Address Gaithersburg, Md. Date signed 7-20-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. True correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07447

CERTIFICATE OF DEATH

93e
Reg. Dist. No. 216

1. PLACE OF DEATH:

County... Montgomery

City or town... Kensington

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yrs.

Hospital, institution, or street address where death occurred:

50 Montgomery Avenue,

How long in hospital or institution? None

3. (a) FULL NAME

UMSTEAD, WILLIAM JOSEPH

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Single

6. (b) Name of husband or wife None

7. Birth date of deceased (mo., day, yr.)

January 14, 1874

6. (c) If alive, give age years

8. AGE:

Years
74Months
74Days
5If less than one day
12

hrs. min.

9. Birthplace... Maryland

(Town, county, and state)

10. Usual occupation... Retired Farmer

11. Industry or business None

12. Name... William T. Umstead

13. Birthplace... Maryland

14. Maiden name... Elizabeth R. Austin

15. Birthplace... Maryland

16. Informant... Miss Anna M. Umstead

Address... Kensington, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof... July 8, 1948
(month) (day) (year)

Cemetery or crematory... St. Mary's Cemetery

Location... Rockville, Maryland

18. Funeral director... Wm. J. L. Umstead

Address... Bethesda, Maryland

19. 7/8 1948

(Date rec'd by registrar)

MM E Jol

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland

County... Montgomery

City or town... Kensington

(If outside city or town limits, write RURAL and give nearest town)

Street No... 50 Montgomery Avenue,

(If rural, give LOCATION)

No

2.(a) If veteran, name war

3. (b) Social Security Number

216-07-4362A

MEDICAL CERTIFICATION

20. DATE OF DEATH

7/5/48

19

9:AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7/5/48 19, to 7/5/48 19.

and that I last saw h... alive on N.D.T. Seen 7/5/48 19.

Immediate cause of death

Cardiac Failure

DURATION

2-3 HR.

Due to... Myocardial Decompression type

Due to...

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, list in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

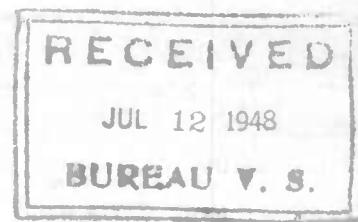
Donald Allen

M. D. or other

Date signed

NOTICE:

Dr. Frank J. Broschart, Dep. Med. Exam., Montgomery County, notified of this death and authorized signature of Medical Certification by Dr. Samuel Allen on July 5, 1948.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

07448

Reg. Dist. No. 217

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Montgomery
City or town Olney
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Montgomery Co. General HospitalHow long in hospital or institution? 9 days

3. (a) FULL NAME

Ralph William Watkins

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife

Mrs. Mabel Watkins

7. Birth date of deceased (mo., day, yr.)

Dec. 22nd 1901 - 46

8. AGE:

Years 44 Months 7 Days 7 If less than one day
hrs. min.

9. Birthplace

Cedar Grove - Maryland
(Town, county, and state)

10. Usual occupation

Clerk

11. Industry or business

MOTHER FATHER

12. Name Alonzo Clayett Watkins13. Birthplace Cedar Grove Ind14. Maiden name Mary S. Barker15. Birthplace Cedar Grove Ind

16. Informant

Mrs. Nona M. WatkinsAddress Clogettville Ind17. Burial, cremation, or removal. Which? Burial Date thereof Aug 1 - 1948

(Burial, cremation, or removal. Which?) (Month) (day) (year)

Cemetery or crematory Damascus IndLocation Montgomery Co. Ind18. Funeral director Ray W. BarkerAddress Clogettville Ind19. (Date rec'd by registrar) 7-31-48 Gertrude B. Laioler

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Montgomery Ind (If outside city or town limits, write RURAL and give nearest town)

Street No. _____ (If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number

218-24-2219

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 July 1948 at 6:50 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

15 July 1948 to 29 July 1948and that I last saw h. u. alive on 29 July 1948Immediate cause of death acute heartVentricular fibrillationDURATION 11 daysDue to Hypertensive Cardio-
Vascular DiseaseDue to Myocardial InfarctionOther conditions Obesity ObesityObesity (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

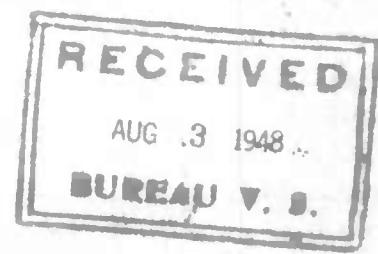
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Jack Schumacher M.D. M. D. or other _____Address Laytonsville, Md. Date signed 29 July 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

07449

217

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County

Halethorpe near Columbia

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Magic Beatrice West

4. Sex

Female

5. Color or race

C

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

April 10, 1890

8. AGE:

Years 58 Months 13 Days 11 less than one day hrs. min.

9. Birthplace

Mongained (Town, county, and state)

10. Usual occupation

Domestic

Henry Warfield

12. Name

Laura Mitchell

13. Birthplace

Mongained

14. Maiden name

Dennis Boswell

15. Birthplace

Rockville, Md. R. F. D.

16. Informant

Burial

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED.

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Halethorpe, near Columbia, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 10 1948, at 3:00 A.M.

I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 15, 1933, to July 10, 1948, and that I last saw her alive on July 10, 1948.

Immediate cause of death

Coronary Thrombosis 1 hour

Due to

Arteriosclerosis

Due to

Hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations none Date of op.

Autopsy results none Date of

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

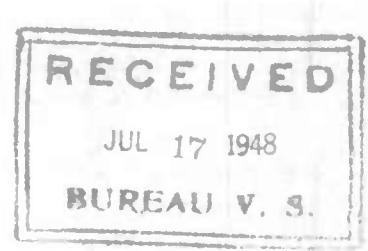
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Webster Newell M.D. M. D. or other

Address No. 300, N. E. Date signed July 13, 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07450

CERTIFICATE OF DEATH

93d
Reg. Dist. No. 123

1. PLACE OF DEATH:

County Maryland
City or town Takoma Park Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 hours

Hospital, institution, or street address where death occurred:

Washington Sam. T. H. Hospital, Takoma Park, Md.How long in hospital or institution? 27 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia County RichmondCity or town Richmond (If outside city or town limits, write RURAL and give nearest town)Street No. 511 W. Grace Street (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Dr. Rebecca M. Whitney4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow6. (b) Name of husband or wife Frank Saget Whitney7. Birth date of deceased (mo. day, yr.) Feb. 16, 18666. (c) If alive, give age years8. AGE: Years 82 Months 4 Days 19 If less than one day 27 hrs. — min.9. Birthplace Duffield, Virginia (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Robert Fitch13. Birthplace Duffield, Virginia14. Maiden name Anna Fitch15. Birthplace Duffield, Virginia16. Informant Hospital RecordsAddress Takoma Park, Maryland17. Transportation Transportation Date thereof July 6, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Richmond, Virginia18. Funeral director Arthur WalterAddress 254 Carroll St. N.W., Takoma Park, D.C.19. Date rec'd by registrar July 6, 1948

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5, 1948 at 11:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 4, 1948 to July 5, 1948
and that I last saw her alive on July 4, 1948

Immediate cause of death

Cerebral hemorrhageDue to Hypertonic CardiacfailureDue to Congestive heart failure unknownOther conditions Include pregnancy within 3 months of death

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

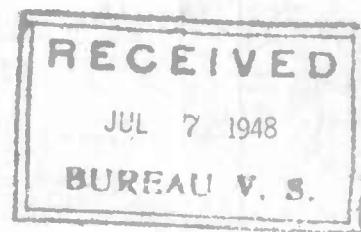
Means of injury Injured at work?

23. SIGNATURE Russell A. Queen, M.D.

M. D. or other

Address Washingtonian, Takoma Park, July 6, 1948

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

07451
Reg. Dist. No. 223

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs.
Hospital, institution, or street address where death occurred: 45-Poplar Ave. Takoma Park, Md.

How long in hospital or institution?

3. (a) FULL NAME

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife Era E. Widmeyer 8. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17, 1888 8. (c) If alive, give age years

8. AGE: Years 60 Months Days If less than one day hrs. m/o.

9. Birthplace Virginia (Town, county, and state)

10. Usual occupation housewife

11. Industry or business

12. Name Rogers

13. Birthplace Virginia

14. Maiden name unknown

15. Birthplace

16. Informant Mrs. Ruth Fenwick

Address 3708-37th. St. Mt. Rainier Md.

17. Burial Date thereof July 29, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fort Lincoln Cemetery

Location 3201-Bladensburg Rd. Holman Manor

18. Funeral director Wm. J. Malley

Address 3200 R. J. Ave. Mt. Rainier Md.

19. (Date rec'd by registrar) July 27, 1948 Mrs. J. S. Severe
(Date rec'd by registrar) July 27, 1948 Deputy Coroner

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George
City or town Mt. Rainier (If outside city or town limits, write RURAL and give nearest town)
Street No. 3708-37th St. (If rural, give LOCATION)

2.(a) If veteran, name war...

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-26 1948 at 7:40 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 12 1947 to July 26 1948
and that I last saw her alive on July 26 1948

Immediate cause of death Acute Respiratory Failure DURATION

Due to Cerebral Hemorrhage

Due to Hypertension

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of...

Where did injury occur? (City or town) (County) (State)

Place at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address 113 Carroll St NW Date signed 7-26-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07452

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County..... Montgomery

City or town..... Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 11 hours

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution?..... 14 hours

3. (a) FULL NAME

WILLSON, Russell

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male

W-US

married

6.(b) Name of husband or wife

Eunice Willson

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

December 27, 1883

8. AGE:

Years 61

Months 6

Days 9

If less than one day hrs. min.

9. Birthplace..... New York

(Town, county, and state)

10. Usual occupation.....

Retired Navy

11. Industry or business

12. Name..... WILLSON, Sidney dec.

13. Birthplace..... N. Y.

14. Maiden name..... STAATS, Mary dec.

15. Birthplace..... N.Y.

16. Informant..... wife: Mrs. Eunice Willson

Address 107 Heskoth Avenue, Chevy Chase, Md.

17. cremation Date thereof..... 7-6-48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Naval Academy Cemetery

Location..... Annapolis, Maryland

18. Funeral director..... S. H. HINES (A.P.)

Address 2901 14th St., N.W., Wash., D.C.

19. 7-6-48 19..... Mary C. Patterson

(Date rec'd by registrar) (Date of death) (Year) (Signature) (Registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Montgomery

City or town..... Chevy Chase (If outside city or town limits, write RURAL and give nearest town)

Street No..... 107 Heskoth Avenue (If rural, give LOCATION)

2.(a) If veteran, name war..... WWI

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 6 July 1948 at 5:23 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep. Med. Examiner's Case

and that I last saw h alive on 19 10 19..... 19..... 19.....

Immediate cause of death.....

Coronary Occlusion

DURATION

15 hours

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results..... confirmed above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.

Frank J. Broschart
FRANK J. BROSCHEART, Dep. Med. Exam.
M. D. or other

Gaithersburg, Md. Date signed 7-6-48

